Thank you for participating in Health Alliance Medicare. This manual is intended as a reference and resource guide for participating Medicare providers and office staff. It contains relevant policies and procedures of the program as well as accompanying explanations and exhibits.

The first goal in our association with our participating providers is to develop a mutually beneficial relationship that results in the delivery of the highest-quality care to our members. As a provider, you are integral to successfully coordinating and providing medical care to Medicare members. Your independence and clinical freedom are essential to program effectiveness. The better you understand the Medicare product and procedures, the greater the likelihood of success for practicing quality, cost-effective medicine with an emphasis on patient education, health promotion and disease management. However, this requires all our participating providers to cooperate and comply with the terms of the Participating Provider Agreement and to fulfill their responsibilities set forth in the agreement and this Provider Manual.

This manual will help maximize the value of the program to you and your Health Alliance Medicare patients. Remember, members should be referred to Health Alliance Medicare Services at 1-800-965-4022 for coverage issues. TTY/TDD users can call 711 or 1-800-526-0844 (Illinois Relay) for the hearing impaired, for coverage issues.

Health Alliance will update this manual annually based on experience and changes in our products. Your input and advice are appreciated. Please direct your comments to your Health Alliance provider relations specialist.
# Table of Contents

## I. Forward

II. Table of Contents

III. Contact Information

IV. Physician Responsibilities

V. Members’ Rights and Responsibilities

VI. Compliance Program

VII. Product Outline

VIII. Service Area

IX. Health Alliance Medicare Staff

X. Quality Management

---

### I. Forward

II. Table of Contents

III. Contact Information

IV. Physician Responsibilities

- Appropriate Conversations with Patients
- Inappropriate Conversations with Patients
- Communications
- Office and Medical Record Requirements
- Provider’s Office Site Inspection Form
- Appointment Scheduling Guidelines
- Accessibility Standards for Behavioral Health Issues
- Policy and Procedure: Medical Records Maintenance
- Health Alliance Ambulatory Review Process
- Policy and Procedure: Ambulatory Review for Primary Care Practitioners
- Credentialing Process
- Policy and Procedure: Application, Credentialing and Recredentialing of Participating Practitioners
- Policy and Procedure: Criteria for Approval as a Participating Practitioner
- Midlevel Information
- Policy and Procedure: Midlevel Providers Recognized by Health Alliance for Network Participation
- Risk Adjustment Coding and Documentation
- Risk Adjustment Revenue Management Department

V. Members’ Rights and Responsibilities

VI. Compliance Program

- Guidance for Business Partners
- Reporting a Compliance Violation, Suspected Misconduct, Privacy or Security
- Incident or a Potential Fraud or Abuse Situation
- Compliance and Fraud, Waste and Abuse Training
- Audit Program and Corrective Action Plans
- HIPAA Privacy Policy for Use, Protection and Disclosure of PHI
- HIPAA Privacy – Authorization Form
- Health Alliance Notice of Privacy Practices
- TC3 Overpayment Recoupment Requests

VII. Product Outline

Overview

VIII. Service Area

- Health Alliance Medicare HMO Illinois Service Area
- Health Alliance Medicare PPO Illinois Service Area
- Health Alliance Medicare HMO Nebraska/Iowa Service Area
- Health Alliance Medicare HMO Washington Service Area

IX. Health Alliance Medicare Staff

X. Quality Management

- Definition of Quality
- Purpose
- Goals
- Objectives
- Program Scope
- Structure of Program
- Medicare Advantage/Special Needs Plan (SNP)
- Key Personnel
- Technical Resources/Systems
- Quality Medical Management Structure
- Risk Adjustment Revenue Management Structure
- National Committee for Quality Assurance (NCQA) and HEDIS®
- HEDIS®
- Audit Requirements
- Access to Services
- Summary of Specifications for HEDIS®, Effectiveness of Care Measures
- Medicare HEDIS Measures
- CMS Star Ratings
Table of Contents

Preventive Health ................................................................. 85
Clinical Guidelines at a Glance ............................................ 86
Policy and Procedure: Clinical Guidelines ............................ 87
Serious Reportable Events .................................................. 89
Adverse Events .................................................................. 89
Sentinel Events ................................................................... 89

XI. Pharmacy Bene .................................................................. 90
Filing Procedures ................................................................. 90
Anesthesia Payment .............................................................. 91
Multiple Scope Billing .......................................................... 92
Annual Coding Changes ....................................................... 92
Health Alliance Specific Reimbursement Policy ...................... 93
Timely Payment ................................................................... 93
Electronic Filing .................................................................... 93
Sample Member ID Cards .................................................... 95
Sample Remittance Advice .................................................. 96
Remittance Form Description ............................................... 99
Sample Explanation of Benefits ............................................ 100
Explanation of Benefits Description ...................................... 101
Policy and Procedure: Medicare Advantage - Non-Clean Claim Definition ........................................... 102
Policy and Procedure: Medicare Advantage - Claim Denial Guidelines ......................................................... 104
Policy and Procedure: Medicare Out-of-Network Clinical Lab Allowable Determination ............................................. 107
Policy and Procedure: Medicare Advantage - Outpatient Prospective Payment System Methodology .................. 111

XII. Medical Management ..................................................... 114
Department Overview ............................................................. 114
Access to Services ................................................................. 114
Turnaround Timeframes for Coverage Requests .................... 114
Preauthorization ................................................................. 115
Inpatient Admissions – HMO/PPO ......................................... 116
Skilled Care and Home Health Services ................................ 116
Denial of Certification ............................................................. 117
Case Management Program .................................................. 117
Satisfaction Survey ............................................................... 118
How to Get More Information ............................................. 118
Health Alliance Request Form ............................................... 119

XIII. Pharmacy Benefits ....................................................... 120
Prescription Drug Benefit Administration ................................ 120
Prescription Plan Options ...................................................... 121
2015 Medicare Pharmacy Benefit Highlights ......................... 122
Medicare Part D Formularies .................................................. 126
Changes to the Medicare Part D Formularies ....................... 126
General Exclusions of the Medicare Part D Formularies .......... 127
Voluntary Pharmacy Programs .............................................. 127
Innovative Pharmacy Initiatives ............................................ 128
Preferred Pharmacy Program ............................................... 128

XIV. Appeals Process ............................................................. 129
Standard Appeal .................................................................. 129
Expeditied Review Request Process ...................................... 130
Expeditied/72-Hour Review .................................................. 131
Fast Track Appeals Review ................................................... 132
Beneficiary Appeals Process ................................................ 133

XV. Grievance Procedures ..................................................... 136
XVI. Advance Directives ......................................................... 137
XVII. Provider Addition/Change Form .................................... 139
XVIII. Midlevel Provider Data Form ........................................ 141
Contact Information

Urbana, Illinois

Health Alliance Medical Plans
Corporate and Administrative Headquarters
301 S. Vine St.
Urbana, IL 61801
Phone: 217-337-8100 or 1-800-851-3379
Fax: 217-337-3438

Springfield, Illinois

Health Alliance Medical Plans
2040 W. Iles Ave., Suite B
Springfield, IL 62704
Phone: 217-698-0022 or 1-888-465-0022
Fax: 217-698-8679

Iowa

Health Alliance Midwest
Phone: 1-800-851-3379
Fax: 217-337-3438

Nebraska

Health Alliance Midwest
Phone: 1-877-917-8550
Fax: 217-337-3438

Washington

Health Alliance Northwest
316 Fifth St.
Wenatchee, WA 98801
Medicare Phone: 1-877-750-3350
Fax: 509-662-0735

Compliance Line
For confidential reporting of potential fraud, abuse and any privacy concerns contact the Health Alliance Compliance Line at 217-383-8304. This service is available 24 hours a day, 365 days a year.

YourHealthAlliance.org

Log on to view
• InterQual® guidelines and medical policies
• the status of a claim
• the status of a preauthorization request

• a patient’s eligibility information
• contracted providers
• and more
Physician Responsibilities

Many Health Alliance plans and products require that members designate a Primary Care Physician (PCP). The PCP may be a Family Practice, General Practice, Internal (Adult) Medicine or Pediatric physician. The PCP is responsible for providing and coordinating the medical care of the member.

Other physician responsibilities include:
1) Availability to beneficiaries 24 hours a day either directly or by call coverage.
2) Cooperating fully with Health Alliance Medical and Quality Management and Risk Adjustment programs, which includes access to medical records for these purposes (See Quality Management and Risk Adjustment Revenue Management sections).
3) Maintaining a conventional patient-physician relationship. Health Alliance Medicare encourages open practitioner-patient communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing medically necessary or appropriate care of the patient.
4) Access to specialists
   • Standing Referral: If a member has a condition that requires ongoing specialty care, he or she may ask his or her PCP for a standing referral. The standing referral can be effective for a time period up to one year or a specified number of visits, whichever is less.
   • Woman’s Principal Health Care Provider (WPHCP): Female members may obtain services from their designated WPHCP (specializing in OB-GYN or Family Practice) without a referral from their PCP. A WPHCP is not authorized to refer to a specialist. All referrals to physicians for specialty services must be made by or approved by the member’s PCP.
   • Before you refer to a specialist or make an appointment for a member, verify that the practitioner is affiliated. Visit our website, www.healthalliance.org, or call the Health Alliance Medicare Services Department.
5) Information disclosure to members. The Illinois Managed Care Reform and Patient Rights Act requires health care providers to supply the following information upon request from a member:
   • Educational background, experience, training and board certification
   • The names of facilities where the providers have privileges
   • Continuing education and compliance with any licensure, certification or registration requirements

Appropriate Conversations with Patients
Health Alliance encourages providers to have open and honest communications with patients. It is recommended that you advise your patients on any of the following:
• the patient’s health status
• medical care and treatment options
• the risks, benefits and consequences of treatment or non-treatment
• the opportunity for the patient to refuse treatment
• future treatment options

Regardless of the patient’s Health Alliance Medicare coverage, the patient has a right to know about all treatment options available. Please encourage patients with coverage questions to call Health Alliance Medicare Services at the number listed on the back of their ID card, or to visit www.HealthAllianceMedicare.org.

Inappropriate Conversations with Patients
It is inappropriate for you or your staff to initiate discussions with patients about disenrolling from any Health Alliance Medicare plan. It is also inappropriate for you or your staff to quote benefit information to your patients; patients should obtain coverage information from Health Alliance Medicare Services.

Communications
The Health Alliance Communications Department is happy to assist you in your communications needs as an affiliated provider. If you have questions, please call the department at 217-337-8083 or 1-800-851-3379, extension 8083.
Physician Responsibilities

1. **Use of the Health Alliance name and logo**

Health Alliance works continuously to maintain a positive brand identity. To this end, Health Alliance closely regulates the use of its name, logo and other identifying references. All providers and other entities must obtain written approval from the Health Alliance Communications Department prior to use of the Health Alliance or Health Alliance Medicare name, logo and/or identifying references in publicly disseminated materials including, but not limited to, newspaper ads, fliers, direct mail, pamphlets, brochures, signage, radio and television broadcasts. We ask that you allow 48 hours for review.

2. **Media Relations**

HMOs, managed care and Medicare Part D are popular media topics and will continue to be so for some time to come. It is in the best interest of our providers and Health Alliance that all media relations be carefully coordinated for consistency.

If you are contacted by the media with inquiries related to Health Alliance Medicare, before you respond:

- Tell the reporter that you are happy to help. Take his or her name and number and say that a representative will return the call promptly.
- Immediately call the Health Alliance Communications Department for guidance.

**Office and Medical Record Requirements**

Health Alliance requires all contracted providers meet our Office and Medical Record Requirements. If a member registers a complaint about one of the criteria listed below, a Provider Relations Specialist will visit your office within 45 calendar days and complete an Office Site Inspection. Offices failing to score 90 percent on the inspection will be resurveyed until the 90 percent threshold is reached. Office sites that fail to reach the 90 percent threshold may be terminated.

**Goals and criteria for provider sites include:**

- Physical accessibility
- Physical appearance/safety—professional, safe, clean and pleasant environment
- Access to care
- Limited or barred access to medications and medical records
- Equipment licensure and appropriate maintenance
- Confidentiality policy
- Medical record maintenance, availability and documentation of service rendered (see attached policy and procedure)

Each provider office will maintain a secured separate medical record for each patient. All medical information shall be maintained in a confidential manner except as required for medical treatment and care. Medical record keeping must meet Ambulatory Review criteria (see Ambulatory Review process on page 12) and focus on the following six critical elements:

1) Significant illnesses and medical conditions are indicated on the problem list.
2) Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
3) Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
4) Working diagnoses are consistent with findings.
5) Treatment plans are consistent with diagnoses.
6) There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
# Physician Responsibilities

**Provider's Office Site Inspection**

*MAKE HEAVY DARK MARKS *
*ERASE CLEANLY TO CHANGE *
*USE #2 PENCIL OR BLACK PEN *

<table>
<thead>
<tr>
<th>Name of Provider/Applicant:</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of Site:</td>
<td></td>
</tr>
<tr>
<td>Date of visit:</td>
<td></td>
</tr>
<tr>
<td>Service Area:</td>
<td></td>
</tr>
</tbody>
</table>

Check Yes, No, or N/A for the following:

## I. Physical Accessibility:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is there adequate parking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is there a ramp for handicapped access?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Are there designated handicapped parking space(s)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is there a handicapped accessible toilet or are facility employees available to assist handicapped patients in restroom if needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## II. Physical Appearance/Safety:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is the exterior of facility presentable and the grounds well maintained?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is the floor or carpet in good repair?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Is the waiting room clean and free of unnecessary clutter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is there adequate space and seating available in the waiting room?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Are the examination rooms clean and free of unnecessary clutter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Are prescription pads kept away from the public?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Are there appropriate disposal containers available for sharps?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Are the medical instruments, hazardous substances and other potentially dangerous materials kept out of patient areas when not being used/monitored by the physician or medical staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Are autoclaves used and properly maintained for sterilization of medical equipment?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## III. Access to Care:(Medical Services)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is a routine appointment available for a new patient within 10 working days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is a routine appointment available for an established patient within 10-14 days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Can a new patient be seen for an urgent problem within 24 hours (same day or next day)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, can the patient be seen elsewhere within 24 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Can an established patient be seen for an urgent problem within 24 hours (same day or next day)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, can the patient be seen elsewhere within 24 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Can a new patient be seen for an emergent need immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, can the patient be seen elsewhere immediately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Can an established patient be seen for an emergent need immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, can the patient be seen elsewhere immediately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. If the average wait time in the office is more than 15 minutes, are patients advised of the potential wait time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Are there an adequate number of examination rooms available per physician?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## IV. Access to Care:(Behavioral Health)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is a routine appointment available for a new patient within 10 working days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Can a patient be seen for an urgent problem within 48 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Can a patient with a non-life threatening emergency be seen within 6 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is a patient with a life-threatening emergency seen immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Physician Responsibilities

### V. Medical Records:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Are medical records easy to access by staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Are medical records stored away from patient access?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Is there a single medical record for each patient with the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the medical record secured within the chart?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are all pages within the chart secured?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does each member of the family have his/her own medical record?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Are there designated sections in the medical record for notes, reports, diagnostic studies, correspondence, etc?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Is a current complete personal/biographical data sheet easily accessible in the medical record?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Is a current complete diagnostic/problem list easily accessible in the medical record?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.</td>
<td>Is there a Policy and Procedure that ensures the confidentiality of medical records?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.</td>
<td>If your Policy and Procedure is written, please attach a copy. If it is oral, briefly explain it below:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VI. Medications:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Are drugs, including manufacturer samples, stored away from patient access?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Are drugs maintained in original manufacturer packaging?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>If a crash cart is maintained, is the cart checked periodically for expiration dates and completeness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Are all Schedule II drugs stored in a locked area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Are any medications stored in a refrigerator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Is the refrigerator with the medications free from food?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS:**

### VIII. Additional Comments:

__________________________________________________________

**Percent Compliance:**

**Signature of Reviewer:**

__________________________

Date:________

**Signature of Provider/Office Representative:**

__________________________

Date:________

**Please note:** deficiencies of any safety issue addressed in Section II (E-I) and Section V (A,B, & D) may result in cessation of the credentialing process. The practitioner must provide written substantiation that safety issues have been corrected within 30 days of the site visit date in order to reactivate processing of the Participating Provider application.
## Physician Responsibilities

### Access Descriptions (NCQA QI Standard 5)

<table>
<thead>
<tr>
<th>Access Descriptions</th>
<th>Definition</th>
<th>Accessibility Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive Care</td>
<td>Well-child exam, annual physical, wellness visits, or gynecological exams</td>
<td>Within 4-8 weeks of request</td>
</tr>
<tr>
<td>2. Routine Primary Care</td>
<td>Primary care for non-urgent symptomatic conditions (differentiates it from wellness visits), such as chronic health problem or ongoing illness in which the member is experiencing no significant change in ADL’s; i.e., HTN, seasonal allergies, medication checks</td>
<td>Within 10-14 days of request</td>
</tr>
<tr>
<td>3. Urgent Care</td>
<td>Sudden, severe onset of illness or health problem requiring medical attention; i.e., sore throat with fever, localizing abdominal pain</td>
<td>Within 1 business day</td>
</tr>
<tr>
<td>4. Emergency Care</td>
<td>Sudden, severe injury or symptoms requiring immediate attention; i.e., chest pain with cardiac HX/unrelieved by NTG, uncontrolled bleeding</td>
<td>Provide and/or refer for emergency care immediately</td>
</tr>
</tbody>
</table>
| 5. After-hours Care | • Practitioners are available to members 24 hours a day either directly or by call coverage*  
• Calls are answered within 45 seconds at least 95 percent of the time | Answering system that arranges access of:  
• ER calls = 30 min  
• Urgent = 24 hr  
• Life-threatening = refer to appropriate health care facility |

Sources: 2011 NCQA Standards and Guidelines

* If you use an answering machine, please make sure the recording specifically includes the following information. NCQA requires messages include instructions for the terms urgent, emergency and life threatening. “If this is an urgent situation, please contact (appropriate contact). If this is an emergency or life-threatening situation, please call 911 or go to the nearest emergency room.”

## Accessibility Standards for Behavioral Health Issues

<table>
<thead>
<tr>
<th>Access Descriptions (NCQA QI Standard 5)</th>
<th>Maximum Allowable Waiting Time (defined by NCQA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non Life-Threatening Emergency</td>
<td>6 hours</td>
</tr>
<tr>
<td>2. Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td>3. Routine Office</td>
<td>10 business days</td>
</tr>
</tbody>
</table>

Sources: 2011 NCQA Standards and Guidelines
PURPOSE OF THE POLICY

To provide guidelines for the maintenance of well-documented medical records at provider sites to facilitate communication, coordination and continuity of care and promote efficiency, safety and effectiveness of treatment, leading to better health outcomes.

STATEMENT OF THE POLICY

The medical records, whether electronic or on paper, communicate the member’s past medical treatment, family history, past and current health status, and treatment plans for their health care.

PROCEDURES

1. Contents and Organization

1.1 A single medical record should exist for each patient.

1.2 Attempts should be made to have all aspects of patient care reflected in the medical record. If some care options, i.e., home care, ambulance records, are not available for inclusion within the record, communication should exist as to the location of those specific care records.

1.3 Contents of the medical record should be secured-fastened.

1.4 Each entry should be indelibly added to the medical record.

1.5 Records should be organized for easy access by filing appropriate information together, i.e., biographical information, progress note, diagnostic studies, past medical history, etc.

• Contents should include, but are not limited to, the following:
  • All services provided directly by the PCP
  • All ancillary services and diagnostic tests ordered by the practitioner
  • All diagnostic and therapeutic services for which a member was referred
  • History and physical
  • Allergies and adverse reactions
  • Problem list
  • Current Medications
  • Documentation of clinical findings and evaluation for each visit
  • Preventive services/risk screening
  • BMI percentile or value
  • Family History
Physician Responsibilities

- Smoking Status (exposure to second-hand smoke for children)
- Alcohol Status (for those over 14 years of age)

1.6 Information should be kept in chronological order within each section.
1.7 Documentation on whether or not a member has executed an advance directive is included in the medical record.
1.8 Documentation of advance directives is placed in prominent part of a member’s medical record.
1.9 All clinical information filed into a patient’s chart should be signed by that patient’s provider in order to note that it has been reviewed prior to filing. For an electronic chart, a time/date stamp of the review date is sufficient.

2. Storage, Availability and Confidentiality

2.1 Each provider site determined and maintains a tracking system for medical record storage and retrieval for various routing needs, such as:
   • Scheduled appointments prior to time of service
   • Same-day scheduled appointments as soon as possible
2.2 In the event a medical record is not available at the time of service, there should be a mechanism to include any related documentation of a visit into the medical record in a timely manner.
2.3 Medical record organization and storage should allow for easy retrieval. Records should be stored on site, in a secure area away from patient/visitor access to ensure confidentiality of PHI.
2.4 Offices must ensure that staff receives periodic training in confidentiality of member information.

3. Follows standards as outlined in:

3.1 *Ambulatory Review for Primary Care Practitioners* policy and Ambulatory Review For that support:
   • Specific medical record documentation criteria
   • Performance Goals
Physician Responsibilities

Health Alliance Ambulatory Review Process

**WHAT is an ambulatory review?**
An ambulatory review is a medical record review conducted by Health Alliance to ensure quality care is provided to our members. It is a process for evaluating a primary care physician’s (PCP) documentation of member visits.

**WHY do we conduct ambulatory reviews?**
The Illinois Department of Public Health (IDPH), per the Health Maintenance Organization Act, requires Health Alliance to have a program for the review and evaluation of medical record documentation of primary care physicians once every two years. In an effort to ensure quality care is provided to our members, Health Alliance scores each ambulatory review, and includes that score as part of the recredentialing process conducted every three years.

**WHO conducts an ambulatory review?**
Ambulatory reviews are conducted by our medical record review staff from the Quality Management Department. The medical record reviewer will contact the primary care physician’s office to coordinate a review date, which will include confirmation of the appointment and a list of charts identified for review.

If there are any questions or concerns at any time during the review process, feel free to contact your medical record reviewer at 217-337-8112 or qualitymanagement@healthalliance.org.

**WHEN is an ambulatory review conducted?**
New Primary Care Physicians are reviewed within their second year of affiliation with Health Alliance, as long as they have 50 or more members on their panel. Subsequent reviews are completed according to the following schedule:

<table>
<thead>
<tr>
<th>Compliance Rating</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>Two Years</td>
</tr>
<tr>
<td>≤ 89%*</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*If a compliance rating is ≤ 89%, a corrective action plan must be submitted to Health Alliance by the Primary Care Physician within 10 working days of receiving their compliance rating.

**HOW is the criteria applied?**
Our medical record reviewers utilize specific criteria based on record keeping, confidentiality and quality of care to evaluate 10–12 member visits for each Primary Care Physician. Some of the criteria may not be applicable for a review based upon the member’s age, gender and/or medical history. If the criteria are not applicable, it will not be factored into the compliance rate.

Health Alliance reviews criteria for ambulatory reviews each year to ensure the best quality of care is being provided to our members. Any changes to the ambulatory review, including new, deleted or modified criteria, will be communicated at least 30 days in advance in writing to the providers.

The following pages provide an overview of the categories.

**Indicated the following:** For monitoring purposes only. Questions will not be scored.

**Section I – Record Keeping/Confidentiality**
- Does staff receive annual training on confidentiality? – The primary care physician office is responsible for providing proof of a written policy regarding confidentiality to the reviewer.
- Does provider have a policy for record retention/retirement? – The primary care office is responsible for providing proof of a written policy regarding record retention and retirement of member records.
- Is Biographical data in the record? – Current biographical data such as member name, address, DOB, etc. is recorded in a designated area.
- Electronic Medical Record?***
Physician Responsibilities

- Provider maintains an active record for each member? – A separate medical record should be maintained for each member.
- Are records organized/stored for easy retrieval?
- Are records stored securely and allows access to authorized personnel only?
- Are records current and complete, containing services by PCP?
- Are records legible?
- Is each entry permanently added to medical records? Information should not be entered in any method that can be removed, washed away or erased.

Section II – Information Specific to Date of Service

- Entry is dated? – The date of selected visit should be documented.
- Chief Complaint? – The reason the member sought care should be clearly documented.
- Was a blood pressure performed (≥ 18 years of age)? – A blood pressure ready for member who sought care should be clearly documented.
- Assessment noted? – Objective and subjective information regarding the member’s presenting complaint should be recorded.
- Current diagnosis present and consistent with findings? – Diagnosis for date of visit should be clearly documented and consistent with findings.
- Plan of treatment, including health education, documented? – The plan of treatment should be consistent with the diagnosis of visit. Health education should be noted for visit, including discussion of treatment, disease processes, diet, exercise, medication side effects, anticipatory guidance, and distribution of informational pamphlets. Follow up correspondence will also be reviewed.
- Is each entry signed/initialed by Primary Care Physician? – All entries, including results of diagnostic tests and services, therapeutic and ancillary services and referrals, should be signed or initialed by the provider. This includes both manual and electronic entries.

Section III – Preventative Care – Other

- Are allergies or NDKA documented? – Notation of allergies and the specific reactions should be noted. If there are no allergies, “NKA” or ‘NDKA” should be noted.
- Medical history, including any relative to current episode of care documented? – Notation of current, failed, past medications should be documented.
- Is current problem list documented? – Problem list for date of visit should be clearly documented.
- Are physicals documented? – Notation of routine physicals should be documented.
- Are medications documented? – Notation of pertinent medical history such as chronic conditions, malignancies, surgeries.
- Is family history documented? – Notation of pertinent family history of all established members should be on a history form during a recent physical or routine visit. If there is not significant history, a notation should be made.
- For members 65+, advanced care planning included? – For members 65+, evidence in the medical record of a living will or power of attorney should be present.
- If advanced care planning is included, is it in a prominent part of the member’s record? – Evidence in the medical record of a living will or power of attorney should be in a prominent part of member record.
Physician Responsibilities

Preventative Care – Preventative Services/Risk Screenings

- Notification of the use of tobacco? – The use of tobacco should be assessed on all members regardless of age. Because of the effects of second-hand smoke, infants and children should be assessed for the presence of a smoker in the home.
- Notation of smoking cessation counseling/referral?
- For members age 18–74 is BMI documented?
- If BMI is documented is it < 25%?**
- For members age 2–17, is BMI percentage documented?
- For members age 2–17, is counseling for nutrition and physical activity documented?
- For members age 50–80, did member have a discussion/counseling with physician regarding colorectal cancer screening?
  - If Y, did member have colorectal cancer test?**
  - If N, did member refuse colorectal cancer test?**

- Immunization Records – Providers should maintain an age appropriate immunization record for all members.
  - For patients two years old:
    ~ Appropriate immunizations completed by 2nd birthday - four DTap, three IPV, one MMR, three HiB, three HepB, one VZV, two Hepatitis A, four PCV, three rotavirus and two influenza vaccinations.
    ~ If all immunizations are not present, were they refused?**
  - For patients 13 years old:
    ~ Appropriate immunizations completed by 13th birthday – one meningococcal, one Tdap, three hpv (female only).
    ~ If all immunizations are not present, were they refused?**
  - For patients ≥ 65 years:
    ~ Appropriate immunizations to be completed? One influenza within the past 12 months and pneumococcal (PCV13 and PPSV23) per ACIP recommendations for adults 65 years and older.
    ~ If immunizations are not present, were they refused?**

- For female patients age 16–25, was sexual activity assessed? For females age 16–25, the chart should contain documentation that sexual activity is assessed, and if the patient is sexually active, a test for Chlamydia is conducted and/or discussed.
  - If Y and sexually active, test for Chlamydia was discussed?**
  - If Y and test was discussed, was it refused?**
Physician Responsibilities

HEADER INFORMATION

<table>
<thead>
<tr>
<th>Owner Department:</th>
<th>Quality and Medical Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Ambulatory Review for Primary Care Practitioners</td>
</tr>
<tr>
<td>Owner:</td>
<td>Director of Quality and Medical Management</td>
</tr>
<tr>
<td>Affected Departments:</td>
<td>Quality and Medical Management, Utilization Management, Credentialing, CPS, and HA Connect</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>05/31/95</td>
</tr>
<tr>
<td>Revision Date:</td>
<td>12/12/13</td>
</tr>
<tr>
<td>Review Date:</td>
<td>12/23/15</td>
</tr>
<tr>
<td>Policy #:</td>
<td>159</td>
</tr>
<tr>
<td>Policy Applies To:</td>
<td>All Primary Care Practitioners with a panel size ≥50 members.</td>
</tr>
</tbody>
</table>

PURPOSE OF THE POLICY

To evaluate medical record documentation by Primary Care Practitioners (PCP) as required by both the Illinois Department of Public Health (IDPH).

STATEMENT OF THE POLICY

Initial ambulatory reviews are conducted within the second year of a practitioner’s affiliation with Health Alliance if an appropriate panel of ≥ 50 members exists. Subsequent reviews are completed according to the schedule defined in the scoring section in the procedure. Practitioners include Pediatrics, Adult/Internal Medicine, Family/General Practice and Specialists designated as PCP’s. Practitioners with a panel size of less than 50 members are not reviewed. Ambulatory Review scores are included as part of the re-credentialing process.

PROCEDURES

1. **HEDIS Supervisor**

   1.1 Generates monthly report for each in the Ambulatory Review database to obtain a list of due and overdue reviews, updated member panel size per provider, as well as a terminated provider listing, for each Medical Record Reviewer.
   
   1.2 Sends copy of the report to assigned Medical Record Reviewer indicating new, overdue and terminated providers that need ambulatory review.

2. **QMM Medical Record Reviewer**

   2.1 Coordinates date for review with practitioner office 3-4 weeks prior to review date.
   
   2.2 Notifies HEDIS Coordinator of appointment date.
   
   2.3 Generates a query of medical records to be reviewed from provider claims history in the Crystal Enterprise software.
   
   2.4 Randomly selects visits/claims from the query report including acute illnesses, complete physical exams, and chronic disease visits for pediatric, adult and geriatric patients. If the query report does not list at least 10 visits (even with a query of visits for the past 12-24 months), request a new query from HEDIS Reporting Manager.
Physician Responsibilities

2.5 Prepares Ambulatory Review database input file prior to review and sends to HEDIS Coordinator to be loaded into database.

3. **HEDIS Coordinator**

3.1 Maintains Ambulatory Review database and makes changes to database structure, forms, programming and reports to reflect changes to Ambulatory Review criteria.

3.2 Upon notification that a database input file is prepared, examine file to validate data and verify that it was entered appropriately.

3.3 Imports data from input file into a database file. Verify that data imported correctly and run any data manipulations necessary (e.g., age calculation).

3.4 Place database file on J drive and notifies the Medical Record Reviewer that it is available.

4. **Medical Record Reviewer**

4.1 Sends a confirmation letter via fax or mail to physician office with an attached list of medical records with date of birth to be reviewed.

4.2 On the day of the review, Medical Record Reviewer shall review database for completeness prior to leaving a practitioner’s office.

4.3 Takes query report to the review. If any of the pre-requested medical records are not available at the time of the review, a different member/visit may be randomly selected and reviewed from the query report.

4.4 For those physicians with a small number of members assigned, it is critical that the sample consist of all the visits requested. If the physician’s office cannot provide documentation to support evidence of a visit for which they billed Health Alliance, this should be noted on the Ambulatory Review form and a report will be made to the Credentialing Committee and included in the Provider Notification Letter.

4.5 If reviewer has any concerns that come to light during the review at the provider’s office, they should fill out the provider site concern form and forward form to the Credentialing Manager.

4.6 Provides feedback and preliminary score to the physician’s office prior to leaving.

4.7 Notifies HEDIS Supervisor and HEDIS Coordinator of any scores that fall below passing, upon return from the visit.

4.8 Forwards the completed database reviews to the HEDIS Coordinator following completion of the review.

4.9 When the HEDIS Coordinator sends a report indicating the provider name, score and date, the Medical Record reviewer should review and approve the Provider Notification Letters being sent out.

5. **QI Coordinator I**

5.1 Upon notification that Record Reviewer has completed reviews, retrieves database file and cleans data by removing extra records and ensuring that the required number of records are completed and scored appropriately.

5.2 Creates and stores provider reports (PDFs) for each provider contained in the database file.

5.3 Updates main Ambulatory Review database by adding data from database file into the main database and entering provider scores and review information into the score tracking table.

5.4 Backs up files by exporting data in main Ambulatory Review database to storage files.

5.5 Notifies HEDIS Coordinator that processing is completed and sends the practitioner reports.
Physician Responsibilities

5.6 A report is sent to the Medical Record Reviewer indicating the provider name, date of review and score. The Medical Record Reviewer should approve prior to sending out the Provider Notification Letters.

6. **HEDIS Coordinator**

6.1 Formats result letter for each practitioner based upon compliance score upon receipt of provider reports.

6.2 Upon completion, files a copy of the letter and distributes letters with the Ambulatory Review Result Sheet to:
   - Practitioner
   - Medical Record Reviewer – Notified that letters are filed, and they can go to that file to review the result letters. A report is also sent to the Medical Record Reviewer indicating the provider name, date and score.
   - Credentialing Department to be filed in the practitioners credentialing file.

6.3 **Scoring**
   - New Primary Care Practitioners meeting minimum panel size requirements are reviewed within their second year of affiliation with Health Alliance. Subsequent reviews are completed according to the following review schedule:
     - Compliance rating:
       - 90%-100% - Next review date 2 years
       - ≤89% - Next review date 6 months in conjunction with a corrective action plan from the practitioner.

6.4 If a practitioner receives <89%, sends memo to appropriate regional medical director with copy of practitioner letter and results.
   - Letter sent to practitioner via Certified Mail.
   - Coordinates communication to the appropriate regional Medical Director, via e-mail, if the practitioner has not submitted a response/action plan within ten (10) working days.
   - Forwards action plan to Credentialing to file.

7. **Regional Medical Director**

7.1 Contacts practitioner if action plan/response is not received within 10 working days from date of notification letter. An email will be generated from the HEDIS Coordinator if this is necessary.

8. **Credentialing Committee**

8.1 Reviews scores at six (6) month re-review results if prior scores ≤ 89% does not improve.

8.2 If problem cannot be corrected and the score does not improve, the Credentialing Committee will evaluate termination of the practitioner’s contract.
Physician Responsibilities

Credentialing Process
The credentialing process applies to all participating practitioners licensed in the states in which Health Alliance is qualified to do business.

The credentialing process is performed at the Health Alliance office in Urbana. Our internal goal is to complete the credentialing process in 35 business days depending on licensure, standing, medical malpractice history, board certification status, responses from references, affiliations and the Credentialing Committee’s review.

All participating practitioners are required by NCQA to complete the credentialing process before being added to the provider network. MDs, DOs and DCs in the state of Illinois will be recredentialed in accordance with the Illinois Department of Public Health regulations on recredentialing. All other providers will be recredentialed every 36 months.

Health Alliance adheres to standards set by the NQCA and Centers for Medicare & Medicaid Services (CMS) to ensure the quality of our provider network. Legal and accreditation requirements mandate a thorough credentialing process for all managed care plans. We have obtained Excellent Accreditation from NCQA for our HMO, POS and Medicare HMO and PPO products.

The following credentialing policies and procedures provide an overview of the process.
PURPOSE OF THE POLICY

The purpose of this policy is to establish the procedures which the Company staff will follow in:

1. processing initial applications from applicants to become Participating Practitioners, and reapplications by former Participating Practitioners and applicants who have either withdrawn prior applications or whose applications to become Participating Practitioners have been denied by the Company;
2. conducting credentialing activities of applicants referred to in Section 1;
3. conducting recredentialing activities required by the Company;
4. ensuring that the Company maintains the highest credentialing standards possible;
5. establishing the procedures to be followed by the Company’s staff in notifying applicants who fail to meet the Company’s criteria to become a Participating Practitioner; and
6. meeting the requirements of applicable NCQA Credentialing Standards, CMS Standards, and by applicable State law.

STATEMENT OF THE POLICY

It is the policy of the Company that:

1. formal procedures and criteria be established for the application, credentialing, and recredentialing of Participating Practitioners;
2. all applicants be treated in a courteous, professional manner, including individuals who do not meet the Company’s criteria to become a Participating Practitioner;
3. approval by the respective Departments of Public Health, or their equivalent, (in all states) in which the Company is qualified to do business, as required for primary care physicians be obtained when required;
4. recredentialing of Participating Practitioners be conducted, not more than once every 24 months unless indicated by quality of care concern(s) and at least every 36 months; and e) to implement procedures to ensure these policies comply, at all times, with all applicable state and federal laws and regulations relating to credentialing of Participating Practitioners.
Physician Responsibilities

APPLICABILITY

This policy applies to all physicians (Medical Doctors and Doctors of Osteopathy), podiatrists, dental practitioners who perform services under medical benefits, optometrists, chiropractors, licensed behavioral health practitioners, nurse practitioners and any other independent healthcare practitioners licensed in the states in which the Company is qualified to do business who are invited by the Company to complete and submit an application to the Company to become a Participating Practitioner, regardless of the product for which the provider is contracted.

PROCEDURES

1. The Credentialing Committee

1.1 The Credentialing Committee (Committee) will:
   • Evaluate potential applicants and make decisions regarding credentialing of applicants and Participating Practitioners.
   • Review and evaluate information received during the credentialing process to determine if the applicant possesses the skills, training, ethics and background necessary to provide care to members.
   • Determine if there is insufficient information on which to base a decision regarding an application, and request additional information from of the applicant or other parties if needed.
   • Withhold processing of applications from applicants who do not provide requested information until information is received, or, in the event of substantial delay and after repeated requests, remove the application from further consideration.
   • Require a new application from any applicant who was removed from consideration prior to reconsideration.
   • Annually review and revise, if necessary, all credentialing applications, policies and procedures, and all other credentialing documentation.

1.2 The Committee shall have the final authority to approve applicants as new Participating Practitioners, and to renew, terminate, or suspend Participating Practitioners as a result of the credentialing process. The Committee’s authority to approve an application, or to renew or terminate a Participating Practitioner is limited to those applicants the Chief Executive Officer of the Company, or his or her designee, has determined applications should be extended to or renewed. The Committee shall hold bimonthly meetings, unless no applications are awaiting review and consideration. The Committee Chairman may call a special meeting of the Committee to review pending applications when the number of applications cannot be reasonably and timely considered by the Committee at its regularly scheduled meetings.

2. Initial Credentialing Process

2.1 The Credentialing process will begin when a complete application has been received. A complete application must contain:
   • A completed credentialing application, either the Illinois Health Care Professional Credentialing and Business Data Gathering form for MD/DO/DC’s in Illinois or the Health Alliance application or the application designated by the state in which the provider practices;
   • Languages (other than English), including American Sign Language, spoken by the applicant or office staff.
• A complete educational and work history, broken down by month and year, with any gaps in excess of six (6) months explained in writing;
• Copy of current, valid Drug Enforcement Administration (DEA) registration from all states in which the applicant currently practices;
• Copy of current, valid certificate of insurance and
• Written explanations of all malpractices actions.

2.2 The Committee, or its designee(s), will obtain and review verification of the following information from a primary source:
• A valid license to practice in all states in which the applicant sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing via the agency website, phone call, or facsimile. (Please refer to Inquiry of Adverse Action Against Applicants and Participating Practitioners Documented by State Regulatory Agencies policy).
• If applicable, clinical privileges in good standing at the hospital designated by the applicant as his or her primary admitting facility. Company staff will verify Clinical privileges with the facility via signed/dated letter, via telephone or via website designated by the hospital.
• A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the applicant sees members. The applicant must provide a photocopy of licenses. Company staff will verify one of the above-mentioned licenses with the appropriate licensing agency via the agency website, phone call, or facsimile.
• Completion of residency, graduation from medical school or graduation from professional school, as applicable. Education is verified via the school’s designated verification service, the educational facility directly, the AMA Masterfile, or the AOA.

2.3 Board certification status may be verified. The following sources are acceptable:
• MDs – Certifacts Online, AMA or the issuing board
• DOs – American Osteopathic Association Website or Certifacts Online
• Podiatrists – American Board of Podiatric Surgery
• Oral Surgeons – American Board of Oral and Maxillofacial Surgery or ABMS

2.4 If the applicant’s Board Certification is verified, Education is not verified.

2.5 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the applicant’s current malpractice insurance policy facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and the covered entity.

2.6 Professional liability claims history. Applicants must provide detailed written information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

2.7 If requested by the Committee, the applicant must provide at least one reference from a peer who is not related to or in practice with the applicant.

2.8 The application shall also include statement by the applicant regarding:
• Reason for any inability to perform the essential function of the position, with or without accommodation
• Lack of present illegal drug use
• History of suspension and/or revocation of any license
• History of felony convictions
• History of loss or limitations of privileges or disciplinary activity
• Complete work history with any gaps of six months or more explained, in writing

2.9 The applicant must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, photocopied or electronically or mechanically produced will not be accepted.
Physician Responsibilities

2.10 The Committee, or its designee(s), will document requests for information and responses regarding the applicant from recognized monitoring organizations.

2.11 The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB) for all providers subject to credentialing.

2.12 The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service(s). This information is to be obtained by Company staff from the appropriate state board of medicine at the time the applicant’s medical license is verified.

2.13 For applicants potentially providing care to Medicare members, documentation received from the NPDB also serves as confirmation that the applicant has no Medicare or Medicaid sanctions.

2.14 Applicants have the right to review information submitted by third parties in support of their credentialing applications, including, but not limited to: malpractice insurance carriers, state licensing boards. Documents available for review do not include references, recommendations, peer review reports or other peer review-related materials and information. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.15 Information obtained during processing of the application that varies substantially from information provided to the Company by the applicant will be fully investigated. The Committee or its designee(s) may contact any other sources it deems necessary, in its sole judgment, to verify the applicant’s response.

2.16 The Committee, or its designee(s), will contact the applicant regarding the conflicting information received. The applicant will be asked to substantiate the information received and will be allowed to make corrections to erroneous information (refer to the Notification of, and Process for, Applicants to Correct Erroneous Information Discovered in Credentialing Process policy). Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.17 The Committee may consider any other factors or information it deems, in its sole judgment, relevant (such as membership in good standing in professional societies, complaints to professional societies, etc.) in making their decision.

2.18 The Application, and all information and materials submitted by the applicant with it, together with all information and materials received in response to requests for information by the Committee, or its designee(s), will be maintained in strictest confidence. All paper information and materials relating to each applicant shall be maintained in a confidential locked file. Access to this file will be restricted to the Committee, or its designee(s). Access to the Credentialing Database and electronic credentialing files are restricted and entered only by pass code.

2.19 The Credentialing Department staff has the option, on a daily basis, to consult with a Health Alliance Medical Director if questions arise.

2.20 Providers who do not meet the Company’s criteria are reviewed by the Committee and either pended for additional information, approved for affiliation as a Participating Practitioner or denied as a Participating Practitioner. The Committee has final authority regarding the acceptance or rejection of all applications. Applicants who are approved for affiliation will be notified in accordance with the CPS New Provider Education policy.

2.21 No members shall be assigned to a provider until their credentialing is complete.

2.22 Health Alliance shall notify the Department of Healthcare and Family Services (HFS) when the credentialing process is completed and provide the results of the process.

2.23 The following shall apply to all applicants who do not meet the criteria to become a Participating Practitioner:

• Any applicant who does not initially meet the criteria for approval as a Participating Practitioner may, in the Committee’s sole discretion, be reevaluated by the Committee.
Physician Responsibilities

according to this policy before notice is given to the applicant that he or she has not been accepted as a Participating Practitioner.

• In conducting its reevaluation of an application under this part, the Committee may consider any factors it deems relevant in making its recommendation regarding final approval or disapproval of an applicant.

• All additional information gathered by the Committee in this process will be maintained in the confidential file.

• The Committee will make a decision regarding the reevaluation of the applicant.

• Applicants who, after the reevaluation, do not meet criteria and are not accepted for affiliation as a Participating Practitioner are to be notified in writing by the Chairman of the Committee within five (5) business days following the Committee’s final decision.

2.24 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the Credentialing Department will perform a criminal background check.

2.25 Applicants have the right to be informed of the status of their application. This information may be requested via phone, fax, email or postal mail. Request will be responded to within three business days. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

3. Recredentialing Process

3.1 Four (4) months prior to the triennial anniversary date of all Participating Practitioners the Committee will recredential each Participating Practitioner. This applies to all practitioners except MD/DO/DCs, in Illinois. These providers will be recredentialed in accordance with the State of Illinois single recredentialing cycle.

• The Credentialing Coordinator will request a Health Care Professional Recredentialing and Business Data Gathering Form from all MD/DO/DCs, in Illinois and will send a renewal application to all other Participating Practitioners.

3.2 The Committee, or its designee(s), will obtain and review the following information from a primary source:

• A valid state license to practice in all states in which the provider sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing.

• If applicable, Clinical privileges in good standing at the hospital designated by the practitioner as his or her primary admitting facility. Company Staff will verify clinical privileges via the hospital’s designated web service, signed/dated letter or telephone.

• A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the provider sees members. The Participating Provider must provide a photocopy of licensure. Company staff will verify that one of the above is active and in good standing with the appropriate state licensing agencies, or appropriate verification service.

• Board certification, as applicable. Board certification status may be verified using one of the sources listed in Section 2.3.

3.3 Changes to languages, other than English and including American Sign Language, spoken by the practitioner or office staff

3.4 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the provider’s current malpractice insurance policy facesheet is to be submitted. The facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and covered entity.
Physician Responsibilities

3.5 Professional liability claims history. Participating Practitioner must submit written detailed information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

3.6 In addition, the Committee shall obtain a new statement from the Participating Practitioner regarding:
   • Reason for any inability to perform the essential function of the position, with or without accommodation
   • Lack of present illegal drug use
   • History of suspension and/or revocation of any license
   • History of felony convictions
   • History of loss or limitations of privileges or disciplinary activity
   • The Participating Practitioner must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, scanned or electronically or mechanically produced will not be accepted.

3.7 The Committee will document triennial requests for information and responses regarding the Participating Practitioner from recognized monitoring organizations.
   • The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB).
   • The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service.
   • NPDB also serves as confirmation that the Participating Practitioner has no Medicare or Medicaid Sanctions.

3.8 During the recredentialing or performance appraisal process for Primary Care Physicians (PCPs) the Committee will review data as described in the Coordinate the Use of Quality Monitoring Information During the Recredentialing Process policy.

3.9 Recredentialing files are available to the Committee if additional information is needed for review.

3.10 The renewal application and all information and materials submitted by the Participating Practitioner with the application, together with all information and materials received in response to requests for information by the Committee, or its designee(s) will be maintained in the strictest confidence. All information and materials relating to each applicant and his or her application shall be maintained in a confidential file for each Participating Practitioner. Access to this file will be restricted to the Committee, or individuals with the express approval of the Committee.

3.11 The Committee has final authority regarding the acceptance or rejection of all renewal applications. Denied applicants will be notified of the Committee’s decision in writing within 14 business days. Approved applicants will be notified via US mail within 5 business days of approval.

3.12 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the credentialing department will perform a criminal background check.

3.13 Recredentialing applicants are entitled to the rights outlined in Sections 2.14, 2.16 and 2.25. They are notified of these rights in the Provider Manual.
4. Documentation

4.1 In documenting verifications obtained during the credentialing and recredentialing processes, the following information is required:

- Oral verifications – verifications taken over the phone must include a note stating the date the verification was completed, the first name or title of the person giving the verification, the information verified, and the initials of the Company staff member taking the verification.
- Fax verifications – verifications accepted via facsimile must include the date the facsimile was received, the name or title of the person giving the verification, the information verified, and the initials of the Company staff member who received the verification.
- Internet verifications – verifications obtained via website will include a print out of the verification screen and will be dated and initialed by the staff member who obtained it. If the verification is too large to print, the company staff member will note, on the document being verified, the date the verification was obtained, the status and expiration date, if applicable, of the document being verified, and the initials of the staff member. If the verification is not printed, the staff member will save the web page as an Adobe Acrobat document and affix a stamp to the document indicating time, date and recipient of the document.
- Mailed verifications – verifications sent to the Company via mail will be initialed and dated by the person receiving the information.

4.2 All notations on documents must be completed either by computer generated date stamp or ink. Use of pencil on verifications is not permitted.

4.3 All information regarding provider demographics, education, licensure, specialty, and hospital affiliations is housed in a Visual Cactus database. Individual provider summaries and reports relating to credentialing providers are generated from this system. Visual Cactus is housed on a server in the Urbana office and technical support is provided by the Health Alliance Information Technology department with assistance from technical staff at Visual Cactus when needed.

4.4 Verification of applicable credentialing information should not occur, or be dated, more than 180 days prior to the Credentialing Committee’s decision.

5. Preparing Provider Files for Presentation to Credentialing Committee or Credentialing Committee Chair

5.1 After the steps outlined in Section 2 have been completed, the Credentialing Coordinator shall determine if the applicant meets Company criteria as defined in Criteria for Approval as a Participating Practitioner policy. If the applicant does meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and present it to the Credentialing Committee Chair, or his/her designee, for approval.

5.2 If the Applicant does not meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and copy all documentation relating to licensure actions, malpractice cases, hospital affiliation action, criminal history, or any other infractions. This documentation will be submitted to the Credentialing Committee for review at its bimonthly meeting.

5.3 After the steps outlined in Section 3 have been completed for a provider undergoing recredentialing, the Credentialing Coordinator adds the provider to the Recredentialing Checklist. The Recredentialing Checklist contains a summary of a provider’s board certification, malpractice history and quality program information. Any documentation related to the Checklist present in the provider file is copied and placed with the Recredentialing Checklist. The Checklist and supporting documentation are submitted to the Credentialing Committee for review at the bimonthly meeting.
Physician Responsibilities

6. Credentialing Providers Who Have Terminated Participation

6.1 A provider who has terminated participation and is otherwise eligible to re-affiliate must complete the initial credentialing process unless they rejoin within thirty (30) days of the effective date of their termination.

6.2 If there are data elements in the provider’s original credentialing/recredentialing file that are less than six (6) months old and can be presented to the Committee prior to expiration, company staff does not have to recollect or re-verify those elements.

7. Updating Provider Information

7.1 When provider information stored in the Credentialing database (Visual Cactus) changes, the database must be updated within thirty (30) days of receipt.

7.2 Updates to provider demographic information that are received by the Credentialing Department are forwarded to Contracting and Provider Services.

7.3 Contracting and Provider Services generates an electronic update.

7.4 Credentialing receives the electronic update and amends the information in the Credentialing Database.

7.5 Information to be updated includes:
   • provider demographic information
   • hospital affiliation
   • board status
   • licenses
   • specialties
PURPOSE OF THE POLICY

The purpose of this policy is to establish the procedures and professional criteria, which are to be followed in processing requests from practitioners to become Participating Practitioners and ensure that applications are complete, accurate and the process is completed in a timely manner.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to maintain standardized, formal criteria for approval as a Participating Practitioner and to provide guidance to the Credentialing Committee (the Committee) in the exercise of its authority to accept or reject application of practitioners to become Participating Practitioners as delegated by Health Alliance Board of Directors.

APPLICABILITY

All practitioners seeking to become Participating Practitioners of Health Alliance in the state of Illinois and all other states in which Health Alliance is qualified to do business.

PROCEDURES

1. Applicants

1.1 Applicants will have (as applicable):
• Successfully completed professional education and training;
• A current, valid license;
• Clinical privileges in good standing at the hospital designated as the primary admitting facility or a referring relationship with an affiliated provider in the same or similar specialty;
• Current, adequate malpractice insurance in amounts determined by the Company;
• A current, valid DEA certificate; and
• A current, valid Controlled Substances license.

1.2 Applicants must meet the following criteria. In the event that an applicant does not meet any or all of the following criteria, the Committee may consider other information or factors that it, in its sole discretion, considers pertinent in making its determination to accept the applicant as a Participating Practitioner.
Physician Responsibilities

- Applicants will have had minimal professional liability claims or suits filed against him or her. The Committee will consider:
  - The number of cases (open and closed).
  - The nature of the cases (open and closed).
- Applicants will be physically and mentally able to practice in their profession, with or without accommodation, and have no impairment due to chemical dependency or substance abuse.
- Applicants will have no restrictions on any license to practice, no current disciplinary activity, or current loss or limitation of clinical/hospital privileges.
- Attainment of Board Certification is not itself a criterion, but may be taken into consideration by the Committee.
- Applicants will have no evidence of significant legal difficulties outside of the practice of medicine that may interfere with the ability of the Participating Practitioner to perform his or her duties under the agreement with Company (felony convictions, extensive civil litigation, etc.).
- Applicants must have no history of previous sanction activity by Medicare or Medicaid (if applicable).

1.3 The Committee may consider any other information and factors it deems relevant (such as membership in good standing of professional societies, complaints to professional societies, etc.) in making its decision.

1.4 The Committee has the right to approve new Participating Practitioners and sites. Subject to the Company’s general right to decide whether or not to renew a contract with any Participating Practitioner, the Committee has the duty to investigate matters brought to its attention it believes are relevant to a Participating Practitioner’s ability to perform his or her duties under the terms of their contract with the Company. In the event the Committee determines such facts exist with respect to a particular Participating Practitioner, the Committee may recommend to the Chief Executive Officer and the Chief Medical Officer that the contract between the Participating Practitioner and the Company not be renewed, be terminated, or the Participating Practitioner’s right to serve the Company’s members be suspended for a recommended period of time.

1.5 The Company does not make credentialing/recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, type of procedures the applicant specializes in, or types of patients the applicant specializes in. To ensure credentialing and recredentialing are conducted in a non-discriminatory manner, the Credentialing Committee will:
  - Submit a biannual report of all providers denied or terminated to the Quality Improvement Committee. The report will include demographic information and basic academic information about the provider and the reason for denial. If QIC determines a pattern of discrimination may exist, a referral will be made to the Compliance department.
  - Ensure that all members of the Committee have signed a non-discrimination statement.

1.6 Applicants that meet all of the Company’s criteria, have no history of malpractice or alleged malpractice, have no history of discipline on any license, have no history of discipline by any educational program, have no criminal history or alleged criminal history, have admitting privileges at an affiliated hospital, and meet the criteria for specialty designation, may be approved for affiliation by review of the Credentialing Committee Chair. In the absence of the Credentialing Committee chair, any physician member of the Credentialing Committee may approve providers for affiliation.

1.7 Company will not credential providers for participation in Federal health care programs if excluded pursuant to section 1128 or section 1128A of the Act.
2. Specialty Designation

2.1 Applicants requesting specialty designation in the provider directory must hold board certification in that specialty or have completed a residency or fellowship in that specialty. Education/Board certification will be verified.

- Providers who respond on the credentialing application that they hold are qualified in multiple specialties may choose any of the specialties to be listed under in the Provider Directory. Board certification or education will be verified.

2.2 Primary Care Practitioner Designation

- Primary Care Practitioners are defined as physicians who provide primary care services (including family practice, general practice, internal [adult] medicine, and pediatrics) and manage routine health care needs. For women, an obstetrician/gynecologist may be considered a PCP.
- Nurse Practitioners and Physician Assistants may be designated as Primary Care Practitioners in limited situations. Those include:
  - Participation in government programs where medical midlevels are designated as PCP’s (i.e. Medicaid) and/or
  - Practice location in a medically underserved area.
- General Medicine/General Practice. Applicants who are not board certified or otherwise qualified to be listed in a specialty must be listed in the credentialing database and Provider Directory under General Medicine/General Practice if they are approved to become a participating provider.

2.3 Requested change of status from specialist to PCP

- If a practitioner has been previously credentialed as a specialist and requests a change in designation to that of PCP they must demonstrate the following:
  - Applicable education to support request, or;
  - Adequate coursework/CME hours to support request, or;
  - Document that greater than 50 percent of their practice is in providing PCP related services.
- Final determination for requested change is at the discretion of the Credentialing Committee.

2.4 PCP with specialty request

- Primary Care Physician who request to be listed also as a medical sub specialist, must provide one of the following sources of information to support the request:
  - Documentation of completion of fellowship in requested subspecialty;
  - Documentation of board certification
  - Documentation of completion of residency in requested subspecialty;
- Surgical specialties are not eligible to be PCPs
- Final determination for requested change is at the discretion of the Credentialing Committee

2.5 No credentialed provider may be designated in a provider directory in a specialty that has not been approved by the Credentialing Committee. In order to ensure accuracy between the specialty designation in the provider directory data and Visual Cactus (credentialing data), the Credentialing Manager will perform a monthly audit of new providers in the provider directory data. Credentialing Manager will confirm that specialty designation is correct. Any inconsistencies will be referred to the Regional Operations Manager for correction.

2.6 No member shall be assigned to a PCP until credentialing process is completed.
3. Use of Practitioner Performance Data

3.1 Participating providers allow the plan to use practitioner performance data, including but not limited to, quality improvement activities and public reporting to consumers.

4. Office Location Change

4.1 A physician who has passed credentialing may change his/her office location within the Health Alliance networks subject to the approval by the Chairperson.

5. Board Certification

5.1 The Credentialing Committee encourages all participating providers to attain and maintain board certification in their specialty. For those providers who elect not to become board certified within five years of completion of residency training or let their board certification lapse, the following is required:
   • Completion of 50 hours of CME annually, in the area of the provider’s specialty.

5.2 The Credentialing Committee, or its designee, will request this information during processing of credentialing/recredentialing application.

6. High Volume Specialty Determination

6.1 Data regarding high volume specialists and high volume behavioral health practitioners is used by the Quality Management Department for a variety of activities. Annually, the Credentialing Manager requests a report to determine which specialists are high volume based on data from the preceding year.

6.2 The methodology used is based on claims data by volume for all provider types for a 12-month period.
   • High volume specialists for the most recent time period are: Cardiology, OB/GYN, and Orthopedics.
   • High volume Behavioral Health Providers are: Social Work, Psychiatry, and Psychology.

7. Assessment of Availability of Primary Care, High Volume Specialty Care, and High Volume Behavioral Healthcare Providers

7.1 Annually, the Quality Improvement Committee assesses the supply of primary care, high volume specialty care and high volume behavioral healthcare providers in the network against geographic data and national physician supply numbers.

7.2 The goal for physician supply numbers is to exceed the minimum supply needed based on a data set supplied by a national vendor. The data set currently in use is from Thomson Reuters/Truven.

7.3 The goal for geographic distribution is for no member to have to travel more than 30 miles or 30 minutes to see a primary care provider. The goal for high volume specialty and behavioral health care is for no member to travel more than 60 miles or 60 minutes to see a provider.

7.4 To assess the supply numbers, the Credentialing Manager requests a report from the Health Alliance Market Intelligence department. An analyst from this department collects Health Alliance physician supply data from the Provider Directory and prepares the report comparing it against the national benchmarks.

7.5 To assess geographic distribution, the Contracting & Provider Services Director uses GeoAccess to map the distribution of Health Alliance providers.
7.6 All data is sent to the Credentialing Manager. The Credentialing Manager prepares a report summarizing all data to present to Quality Improvement Committee.

7.7 QIC reviews the data and makes recommendations to Contracting & Provider Services.
Physician Responsibilities

Midlevel Information
To ensure accurate and prompt claim reimbursements, Health Alliance requires all practitioner offices to submit information about certain midlevel providers in their practice (see list, page 33). Please complete and return the Midlevel Provider Data Form (located on page 141) for each new midlevel practitioner employed by your practice, and be sure to include copies of the:

• midlevel practitioner’s state license
• state controlled substance license
• DEA registration certificate.

This information will be used by Health Alliance to verify the midlevel practitioner’s license. Please use the Provider Addition/Change Form (located on page 139) to notify Health Alliance when a midlevel practitioner terminates employment.

Proper notification of midlevel practitioners will ensure timely payment of claims.

Midlevel supervision: By contracting with a physician, Health Alliance assumes the physician is the primary provider of medical care for beneficiaries and therefore, should be present to see patients in the office at least 50 percent of the time the office is open. The Credentialing Committee must review exceptions to this requirement.

If you have any questions about requirements for midlevel credentialing, please contact a Health Alliance contract coordinator at 1-800-851-3379, extension 3445.

Proper Credentials Ensure Quality Health Care
Midlevel providers play an important role in providing care for our members, and we want Health Alliance members to receive appropriate, high-quality health care from certified or licensed midlevels.

We only reimburse claims submitted by contracted midlevel providers with valid and current state licensure. If you are a member of a contracted group practice, and a claim reimbursement is disallowed because these requirements are not met, by contract you cannot bill an HMO member.

Midlevel Service Billing Clarification
When billing for services provided by a midlevel, please use his or her provider number. Health Alliance does not need the supervising physician’s provider number as long as the midlevel’s provider number is given. When a new midlevel joins your office, please be sure to complete and return the Provider Addition/Change Form and Midlevel Provider Data Form located on pages 139 and 141. Billing for services provided by an individual delivering care outside their scope of practice is considered fraudulent billing and subject to recovery, termination of contract and prosecution to the full extent of the law.
PURPOSE OF THE POLICY

To define which midlevel provider types Health Alliance recognizes for network participation.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to only allow midlevel providers who hold a valid license or certification in their profession to provide services to members. The Credentialing department verifies such licensure or certification in accordance with Verification of Licensure of Midlevel Providers policy and procedure.

PROCEDURES

1. Mental Health Midlevel Provider (must be credentialed)

1.1 Clinical Professional Counselor
   • LCPC, Licensed Clinical Prof. Counselor
   • LPC, Licensed Professional Counselor
   • LC, Licensed Counselor
   • LMHC, Licensed Mental Health Counselor (IA)
   • LP, Licensed Psychologist (IA)
   • LCPC, Licensed Clinical Professional Counselor

1.2 Social Worker
   • LCSW, Licensed Clinical Social Worker
   • LSW, Licensed Social Worker
   • LISW, Licensed Independent S.W. (Iowa)
   • LMSW, Licensed Masters S.W. (Iowa)
   • LBSW, Licensed Bachelors S.W. (Iowa)

1.3 Marriage/Family Therapist
   • LMFT, Licensed Marriage Family Therapist
   • LMFC, Licensed Marriage Family Counselor
   • NP, PA, APN, PA-C with a specialty in mental health
Physician Responsibilities

1.4 Autism
- BCBA Board Certified Behavioral Analyst (must have Master’s Degree, be certified by the Behavioral Analysts Certification Board and have completed 225 graduate classroom hours.
- BCaBA – Board Certified Assistant Behavioral Analyst (must have Bachelor’s Degree, be certified by The Behavioral Analysts Certification Board and have completed 135 classroom hours)

2. Medical Midlevel Provider

2.1 Nurse Practitioner/Physician Assistant
- PA, PA-C, Physician Assistant
- APN, Advanced Practice Nurse
- APRN, Advanced Practice Registered Nurse
- ARNP, Advanced Registered Nurse Practitioner
- CFNP, Certified Family Nurse Practitioner
- CGNP, Certified Geriatric Nurse Practitioner
- CNP, Certified Nurse Practitioner
- CNS, Clinical Nurse Specialist
- CPNP, Certified Pediatric Nurse Practitioner
- CRNA, Certified Registered Nurse Anesthetist
- FNP, Family Nurse Practitioner
- FNPC, Family Nurse Practitioner, Certified

2.2 Nurse Practitioner
- NP, Nurse Practitioner
- RNFA, Registered Nurse First Assistant
- RNP, Registered Nurse Practitioner

2.3 Nurse Midwife
- CNM, Nurse Midwife

3. Ancillary Midlevel Providers

3.1 Physical Therapist
- PT, Physical Therapist
- RPT, Registered Physical Therapist
- LPT, Licensed Physical Therapist

3.2 Occupational Therapist
- OT, Occupational Therapist
- OTRL, Occupational Therapy, Registered License

3.3 Speech Therapist
- ST, Speech Therapist
- SP, Speech Pathologist
- SLP-CCC, Speech Language Pathologist

3.4 Audiologist
- CCC-A

3.5 Dietitian
- RD, Registered Dietitian
- LD, Licensed Dietitian
- LNC, Licensed Nutrition Counselor
Physician Responsibilities

Risk Adjustment Coding and Documentation
Health Alliance Medicare contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) plans. CMS payment to Health Alliance Medicare is based on risk adjustment methodology that reimburses health plans based on the health of the individual enrollee. The risk of the individual enrollee is determined by the diagnosis codes included on the claim submitted to Health Alliance Medicare and passed to CMS.

Medicare has classified about 3,000 of the 15,000 International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes into Hierarchical Condition Categories (HCCs) designating higher-cost within the HCC conditions affecting the disease burden population, such as diabetes, kidney failure, atrial fibrillation, etc. When patients are assigned ICD-9 codes, Medicare sees those beneficiaries as sicker than the “average” Medicare beneficiary resulting in higher reimbursement from CMS. In this program we are reimbursed by diagnosis codes, not Current Procedural Terminology (CPT) codes.

The Provider’s role in this process is to submit medical record documentation that is clear, concise, consistent, complete and legible. All diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. To that end, an increased emphasis is being placed by Health Alliance Medicare on provider education and recommendations related to HCCs, diagnoses and documentation regulations.

HCCs are given a severity ranking, the higher medical risk to the patient, the higher the ranking. It is important to follow normal coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a particular visit must be documented. The medical record documentation must support the diagnosis was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the CMS instructions for Risk Adjustment implementation. In addition, the diagnosis must be coded according to ICD-9-CM Guidelines for Coding and Reporting. Codes with a higher HCC ranking result in more “credit.” For example, if a patient is diabetic and has other problems associated or caused by the diabetes, use the more specific codes 250.4x or 250.5x, etc. instead of 250.0x

Scenario
This example provides an illustration of how coding specificity can impact risk adjustment payments.

Herny Smith is a 68-year-old male living in Champaign. He has a history of colon cancer, anemia and active adult onset diabetes, controlled by medication. The diabetes has caused progressive neuropathy with weakness in his extremities. He now presents to an Internal Medicine physician of office for weakness and headaches.

After an examination and blood count, the final impression is: weakness and headaches due to continued anemia and diabetic neuropathy.

When diagnoses are reported at the highest level of specificity consider these two scenarios:

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ICD-9-CM Code 280.9 – Anemia (Not an HCC)</td>
<td>• ICD-9-CM Code 280.9 – Anemia (Not an HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code 250.00 – Diabetes (HCC)</td>
<td>• ICD-9-CM Code 250.60 – Diabetes with Neuropathy (HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code 357.2 – Neuropathy (HCC)</td>
<td>• ICD-9-CM Code 357.2 – Neuropathy (HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code V10.05 – Hx of Malignant Neoplasm, Colon (not an HCC)</td>
<td>• ICD-9-CM Code V10.05 – Hx of Malignant Neoplasm, Colon (not an HCC)</td>
</tr>
</tbody>
</table>

Scenario 2 would be coding to the highest level of specificity. The patient has diabetes with neuropathy, not just diabetes.
The coding differences in our example affect the monthly payment from Medicare to Mr. Smith’s MA plan to cover medical expenses in the following way:

<table>
<thead>
<tr>
<th>Coding Scenario 1 (2015 Payment Year)</th>
<th>HCC 2013</th>
<th>Risk Score 2013</th>
<th>Capitation Rate (Champaign Co.)</th>
<th>Monthly Revenue</th>
<th>Yearly Revenue</th>
<th>HCC 2014</th>
<th>Risk Score 2014</th>
<th>Capitation Rate (Champaign Co.)</th>
<th>Monthly Revenue</th>
<th>Yearly Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Male (65-69)</td>
<td>0.283</td>
<td>698.11</td>
<td>$197.57</td>
<td>$2,370.84</td>
<td></td>
<td>0.288</td>
<td>698.11</td>
<td>$201.06</td>
<td>$2,412.67</td>
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</tr>
<tr>
<td>ICD 9 CM Code:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>280.9 Anemia (Not HCC)</td>
<td>0.283</td>
<td>698.11</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
<td>0.288</td>
<td>698.11</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>250.00 Diabetes (HCC)</td>
<td>0.00</td>
<td>698.11</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
<td>0.00</td>
<td>698.11</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
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<tr>
<td>357.2 Neuropathy (HCC)</td>
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<tr>
<td>ICD 9 CM Code:</td>
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<td></td>
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</tr>
<tr>
<td>V10.05 Hx malig neop, colon (Not HCC)</td>
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<td>$224.09</td>
<td>$2,689.08</td>
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<td>0.368</td>
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<td>TOTAL</td>
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<td>$6,123.82</td>
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<td>698.11</td>
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<td>0.791</td>
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<td>Blended Score</td>
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<tr>
<td>Coding Intensity Adjustment</td>
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<td>GRAND TOTAL</td>
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</tbody>
</table>

<table>
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<tr>
<th>Coding Scenario 2 (2015 Payment Year)</th>
<th>HCC 2013</th>
<th>Risk Score 2013</th>
<th>Capitation Rate (Champaign Co.)</th>
<th>Monthly Revenue</th>
<th>Yearly Revenue</th>
<th>HCC 2014</th>
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<tr>
<td>250.0 Diabetes (HCC)</td>
<td>0.00</td>
<td>698.11</td>
<td>$ -</td>
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<td>ICD 9 CM Code:</td>
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<tr>
<td>V10.05 Hx malig neop, colon (Not HCC)</td>
<td>0.321</td>
<td>698.11</td>
<td>$224.09</td>
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<td>TOTAL</td>
<td>0.975</td>
<td>698.11</td>
<td>$680.66</td>
<td>$8,167.89</td>
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<td>0.656</td>
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<td>$457.96</td>
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<td>Normalization Factor</td>
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<td></td>
<td></td>
<td>0.978</td>
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<tr>
<td>Total Before Blend</td>
<td>0.983</td>
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<td>$660.09</td>
<td>$8,029.08</td>
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<tr>
<td>Coding Intensity Adjustment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.16%</td>
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<tr>
<td>GRAND TOTAL</td>
<td>0.835</td>
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<td>$582.92</td>
<td>$6,995.06</td>
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</table>

The normalization and coding intensity are CMS-mandated factors for consideration on all HCCs. After compiling calculations, our data confirms that a positive gain of $996.90 in this calendar year is the end result when electing to code to the highest level of specificity.

**Risk Adjustment Data Validation**

Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the MA organization are supported by participating provider medical record documentation for an enrollee. The primary goals of CMS through risk adjustment data validation are to:

- Identify
  - Confirmed risk adjustment discrepancies
  - MA organizations in need of technical assistance to improve risk adjustment data quality
- Measure
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- Improve/Inform
  - Quality of risk adjustment data
  - The CMS-Hierarchical Condition Category (CMS-HCC) model
Physician Responsibilities

Risk Adjustment Revenue Management Department

As a local Health Plan providing coverage to enrollees in our community, Health Alliance is committed to maintaining affordable premiums and quality care. Correct diagnosis coding is critical to ensure we have an accurate assessment of the health status of and expected level of care for our membership. Our Risk Adjustment Revenue Department has financial accounting, reconciliation and analysis, certified coding consultants and analysts and advanced practitioner staff to monitor ongoing issues related to our members’ needs where their chronic conditions are concerned.

In a sense, Health Alliance has brought the return of the house call for targeted members by sending mid-level practitioners into members’ homes for comprehensive Health Risk Assessment (HRA) and complex case management. These assessments are then provided to the primary care physicians and Health Alliance’s Medical Management Department to assist in care coordination.

Health Alliance regularly performs provider medical record reviews to ensure correct diagnosis coding compared to codes submitted on claims. As such, our coding team requests electronic or paper copies of medical records for our members that can be provided on a flash drive, CD, via secured email, remote or on-site access to EMR systems, paper for pick up, delivery, or through fax. Coding analysts may also need onsite visits to review members’ medical records. The information provided should include, but should not be limited to:

- Face sheet
- History and physical exams
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic reports
- Discharge summaries


All erroneous data identified in the audit process must be corrected by the health plan and sent to CMS; delay in reimbursement could occur in these situations.
Members’ Rights and Responsibilities

• Right to receive information in a way that works for you (in languages other than English, in Braille, in large print or other alternate formats, etc.).
• Right to be treated with fairness and respect at all times.
• Right to ensure that you get timely access to your covered services and drugs.
• Right to protection of the privacy of your personal health information.
• Right to receive information about the plan, its network of providers and your covered services.
• Right to make decisions about your care.
  – You have the right to know your treatment options and participate in decisions about your health care.
  – You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.
• Right to make complaints and to ask us to reconsider decisions we have made.

• Responsible for getting familiar with your covered services and the rules you must follow to get these covered services.
• Responsible to notify us if you have any other health insurance coverage or prescription drug coverage in addition to our plan.
• Responsible to tell your doctor and other health care providers that you are enrolled in our plan.
• Responsible to help your doctors and other providers help you by giving them information, asking questions and following through on your care.
• Responsible to be considerate.
• Responsible to pay what you owe.
• Responsible to tell us if you move.
• Responsible to call Health Alliance Medicare Services for help if you have questions or concerns.
Compliance Program

Guidance for Business Partners
Health Alliance Business Partners are expected to:

- Maintain a compliance plan which includes policies and procedures addressing prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance. Medicare guidelines allow nominal giveaways of no more than $15. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations.
- Be free of inappropriate conflicts of interest.

A copy of the Ethics and Compliance in the Workplace: A Guide to Employee Conduct is available to you upon request by calling 1-800-851-3379.
Compliance Program

Reporting a Compliance Violation, Suspected Misconduct, Privacy or Security Incident or a Potential Fraud or Abuse Situation
If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Scott McAdams, Director of Compliance and Compliance Officer
1-800-851-3379 ext 3238 or 217-365-3238

Traci Jensen, Compliance Programs Manager and Privacy Officer
1-800-851-3379 ext 3418 or 217-337-3418

Wyatt Scheiding, HIPAA Security Officer
1-800-851-3379 ext 3493 or 217-337-3493

Health Alliance Compliance Line (this avenue can be anonymous)
217-383-8304 or 1-855-371-4640

The Office of the Inspector General
1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950

The Center for Medicare and Medicaid Services (CMS)
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
Health Alliance is committed to maintaining a reputation for excellence by establishing the highest ethical principles and professional standards and ensuring compliance with applicable state and federal laws. These principles and standards apply to our relationship with members, providers, employer groups, vendors, consultants and regulatory agencies and coworkers.

In support of this commitment, and in conformance with the standards set forth in the U.S. Federal Sentencing Guidelines and the compliance program guidance for Medicare Advantage Organizations (MAO), Part D Plan Sponsors and Medicare-Medicaid plans published by the Center for Medicare and Medicaid Services, and applicable state requirements Health Alliance established a Corporate Compliance Program.

This Program includes an Employee Guide to Conduct and policies and procedures designed to assist Health Alliance employees achieve and maintain compliance.

Health Alliance fosters an environment in which compliance with laws, regulations and sound business practices are woven into the corporate culture.
Compliance Program

Commitment to Compliance

The Compliance Program focuses on the prevention and detection of violations of federal and state laws as well as corporate policies and procedures and promotes reporting of suspected misconduct, compliance violations, privacy and security incidents and potential fraud or abuse situations.

There is no retribution for asking questions, raising concerns or reporting possible violations in good faith.

Commitment to Compliance

Your understanding of this commitment and your willingness to partner with Health Alliance in adhering to these principles and standards are essential to the well-being of our members and to the success of the business partnership.

A copy of the Health Alliance Ethics and Compliance in the Workplace: A Guide to Employee Conduct accompanies this education and is also available to you upon request by calling 1-800-851-3379, ext 3418.

Guidance for Business Partners

Health Alliance Business Partners are expected to:

- Maintain a compliance plan which includes policies and procedures addressing prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performance duties for Health Alliance. Medicare guidelines allow nominal giveaways of no more than $15. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations to Health Alliance.
- Be free of inappropriate conflicts of interest.
The Center for Medicare and Medicaid Services (CMS) requires MAOs, Part D Sponsors and Medicare-Medicaid plans to provide Compliance and Fraud, Waste and Abuse (FWA) training to all entities and individuals who meet the definition of first tier, downstream or related entity. First tier, downstream and related entities that have met the FWA certifications through enrollment in the fee for service Medicare program or accredited as a DMEPOS suppliers are deemed to have met the FWA training and education requirement.

Citation: F.R. Vol. 72, No. 233, December 5, 2007
F.R. Vol. 75 No 19678 effective June 7, 2010

Key Terms and Definitions
- **First Tier entity** means any party that enters into a written arrangement, acceptable to CMS, with an MAO to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage (MA) program.
- **Downstream entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAO and the first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- **Related entity** means any entity that is related to the MAO by common ownership or control and (1) performs some of the MAO management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO at the cost of more than $2,500 during a contract period.

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representation or promises) any of the money or property owned by or under control of any health care program.

Waste is the over-utilization of services or other practices that directly or indirectly result in unnecessary costs; misuse of resources.
Fraud, Waste and Abuse

Key Terms and Definitions

Abuse includes actions that may, directly or indirectly, result in:
- unnecessary costs to the Medicare Program, improper payment,
- payment for services that fail to meet professionally recognized
  standards of care, or services that are medically unnecessary. Abuse
  involves payment for items or services when there is no legal
  entitlement to that payment and the provider has not knowingly
  and/or intentionally misrepresented facts to obtain payment. Abuse
  cannot be differentiated categorically from fraud, because the
  distinction between “fraud” and “abuse” depends on specific facts and
  circumstances, intent and prior knowledge, and available evidence,
  among other factors.

Fraud, Waste and Abuse

Health care fraud is a major reason why the cost of health care in the
United States continues to rise at an alarming rate.

Individuals who participate in fraud schemes and those who fail to
report health care fraud contribute to those rising costs.

Schemes and fraudulent billing practices not only cost taxpayers, they
put beneficiaries health and welfare at risk.

For example: Two patients died because of a scan that involved
recruiting homeless and other vulnerable adults for unnecessary
heart catheterizations and angioplasties. The doctors and
administrators behind the scheme were caught and prosecuted.

Fraud, Waste and Abuse

Fraud is a criminal act, abuse is not

Fraud is distinguished from abuse in that, in the case of fraudulent
acts, there is clear evidence that the acts were committed knowingly,
willfully and intentionally or with reckless disregard.

If fraud occurs, a crime has been committed and criminal prosecution
may take place.

In most cases of abuse a crime has not been committed.

The major difference is the intent of deception from the person.
Fraud, Waste and Abuse

Fraud and Abuse Opportunities
There are many ways fraud and abuse can occur. Examples include:
- Identity Swapping
- Identity Theft
- Kickbacks
- Marketing Schemes
- False Claims
- Duplicate Billing
- Abuse of the System

Who can commit fraud and abuse?
- Beneficiaries/members
- Providers, pharmacies and billing companies
- Pharmacy benefit management companies (PBMs)
- Insurance Companies
- Employees
- Brokers/Agents
- Employer groups

The following slides are some examples of potential fraud and abuse under the Medicare program.
This is not intended as a comprehensive listing of all possible fraud and abuse schemes.
## Fraud, Waste and Abuse

### Beneficiary / Member
- Use of another’s insurance card to obtain prescription drug benefits or medical services
- Loaning one’s ID card to someone else to obtain prescription drug benefits
- Adding ineligible dependents to the plan
- Falsifying information on the application
- Excessive trips to the emergency room to obtain controlled substances
- Submitting prescription drug receipts that are forged or altered for reimbursement
- Resale of drugs on the black market
- Identity theft

### Provider or billing company – Medical Services
- Intentionally not giving the member the amount of drugs prescribed
- Intentionally dispensing a different drug than the doctor prescribed, for purposes of saving money (prescription drug switching)
- Billing for drugs that a member did not receive
- Billing under another provider’s Tax Identification Number (TIN) to obtain reimbursement for services
- Duplicate billing
- Billing for services performed by non-licensed persons
- Regularly prescribing unnecessary drugs
- Illegal remuneration schemes such as selling prescriptions
- Script mills
- Theft of prescribers prescription pads

### Pharmacy Benefits Manager (PBM)
- Prescription drug switching
- Unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug
- Inappropriate formulary decisions
- Prescription drug splitting or shorting
- Failure to offer negotiated prices
Compliance Program

Fraud, Waste and Abuse

**Insurance Company**
- Discriminating against an individual, including not allowing the individual to enroll in a plan because of age, health, race, religion or income
- Charging a member more than once for premium costs
- Not paying for covered medical services or drugs
- Making false statements in advertising materials that influence consumers to make buying decisions

Fraud, Waste and Abuse

**Employee or Broker**
- Encouraging an individual to enroll in a richer benefit plan to receive a higher commission and, once the individual is on the plan, switching him or her to a reduced benefit plan without the member being fully aware of the implications (bait and switch)
- Encouraging a member to disenroll from a plan
- Offering cash to enroll in a MA or Prescription Drug plan
- Offering a gift worth more than $15 to sign up for MA or Prescription Drug plan
- Making false statements to an individual or member
- Altering claims or medical records for a service to be covered that is not normally covered
- Fabricating claims

Fraud, Waste and Abuse

**Employer**
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- Providing false employer or group eligibility information to secure health care coverage
- Changing dates of hire or termination to expand dates of coverage
Compliance Program

Your Role
As a business partner you must participate in compliance and FWA training on an annual basis. Report any suspected misconduct, compliance violation, privacy or security incident or potential fraud and abuse activity.

Reporting
If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Health Alliance Compliance Line
217-383-8304 or toll-free 855-371-4640

The Office of the Inspector General
800-HHS-TIPS (800-447-8477)

Non-Retaliation for Reporting
Good faith reporting of suspected fraud, waste and abuse is expected and accepted behavior.
Anyone who in good faith report a violation is protected from any retaliation.
A number of laws contain whistleblower protection including the False Claims Act.
The False Claims Act

The False Claims Act establishes a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the government.

Those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government’s damages for the false bills plus civil penalties from $5,000 to $10,000 per false claim.

A private citizen or “whistleblower” with knowledge of past or present fraud on the federal government is permitted to sue on behalf of the government to recover civil penalties and damages. The whistleblower has guaranteed job protection under the Act and is entitled to a share of the government’s total recovery.

The False Claims Act Enforcement

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

Penalties

Civil
- Not less than $5,500 and not more than $11,000 per false claim plus three times the amount of the false claim
- Exclusion from participation in federal health care programs
- Additionally, under the Patient Protection and Affordable Care Act, the Office of Inspector General (OIG) may impose civil monetary penalties of up to $50,000 for each false record or statement and for knowingly failing to report and return an overpayment within the required timeframe.

Criminal
- Courts can impose criminal penalties against individuals and organizations for willful violations

Anti-kickback

The Federal Anti-Kickback laws make it a criminal offense to knowingly and willfully offer, pay, solicit or receive remuneration of any kind to induce or reward referrals of items or services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
Compliance Program

**Anti-kickback Enforcement**

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

**Penalties**

**Criminal:**
- Violation is a felony
- Fine of up to $25,000 and/or prison for up to 5 years

**Civil:**
- Violation may result in civil monetary penalties of up to $50,000 for each violation of the statute plus damages of up to three times the total amount of the unlawful remuneration

**Exclusion:**
- Violation may result in exclusion from participation in the Medicare and Medicaid programs

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**Conflicts of Interest**

Conflicts of interest arise when a member of the board, an officer, director, manager, Pharmacy and Therapeutics Committee member, employee or contractor is in a position to influence either directly or indirectly Health Alliance business decisions that could lead to gain for the individual, the individual’s relatives or others to the detriment of Health Alliance and its mission and integrity.

**Examples:**
- Ownership of a significant financial interest in any outside concerns that does business with, or is a competitor of Health Alliance.
- Provision of services for compensation to any outside concern that does business with, or is a competitor of Health Alliance.

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**Excluded Entities or Individuals**

Health Alliance may not contract with or employ entities or individuals who are excluded from doing business with the government.

Health Alliance monitors the Office of Inspector General (OIG) Exclusion List and General Service Administration (GSA) List on a monthly basis.

Non-compliance and/or fraudulent behavior is unacceptable and subject to termination of the business relationship with Health Alliance.
### Additional Resources

- **CMS Prescription Drug Benefit Manual**

- **Code of the Federal Register (see CFR 422.503 and CFR 423.504)**

- **Office of the Inspector General**
Audit Program and Corrective Action Plans

The goal of Health Alliance’s Provider Audit Program is to proactively analyze claims data and confirm that claim submissions accurately represent the services provided to Plan members, and to ensure that billing is conducted in accordance with Current Procedural Terminology (CPT) & HCPCS guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures to combat potential healthcare fraud, waste, and abuse.

As part of an ongoing program to monitor plan payment integrity and cost-effective medical care, and as a supplement to other Health Alliance Compliance initiatives the objective of the Provider Audit Program is to ensure that Health Alliance fulfills its responsibility to its enrollees and/or Plan sponsors by identifying and recovering inaccurate payments which are a result of inadvertent or intentional provider actions or misrepresentations.

The areas reviewed by the Provider Audit Program include, but are not limited to, the following:

- Billing for services that were not provided
- Intentional misrepresentation
- Billing services at a higher level than which was rendered
- Failure to comply with the Contract, Plan policies and procedures, and/or other relevant guidelines, regulations or laws
- Inadequate documentation to support the services billed
- The deliberate performance of unwarranted or medically unnecessary services for the purpose of financial gain

In connection with the provisions set forth in the contract with Health Alliance providers shall:

- Provide or arrange for health services for members in an economic and efficient manner consistent with professional standards of medical care generally accepted in the medical community at the time
- Provide or authorize for members only those services which are medically necessary
- Maintain complete and up-to-date medical records
- Bill in accordance with the American Medical Association’s CPT guidelines and HCPCS guidelines
- Comply with all Health Alliance payment policies

In connection with the preceding provisions, Health Alliance’s Provider Audit Program may:

- Audit providers
- Recover funds from providers who engage in improper and/or inappropriate billing practices. Although audits are usually based on claim submissions for up to a five-year period, audits and medical record requests will only be subject to a five year request. Recoupment requests will extend back no further than one year from the payment date.
- Suspend/Off-Set future claim payments once improper billing practices are suspected
- Close the provider’s panel or terminate the provider in addition to recovering overpayments if the provider intentionally engages in improper billing practices
- Access medical records of past and present Health Alliance members

Note: Providers shall mail/fax or grant Health Alliance access to review and copy member medical records within a reasonable period of time following such request. For purposes of this document, “reasonable” shall be defined as a maximum of two weeks from Health Alliance’s initial request for access, unless a different time period is mutually agreed upon by the Plan and the provider.

The provisions set forth in the foregoing description of the Provider Audit Program apply to all plans, programs, contractual arrangements and products administered by Health Alliance.
Corrective Action Plans
A Corrective Action Plan (CAP) is a plan of action developed to address findings and observations that have been identified by the Health Alliance Special Investigations Unit and approved to request remediation on by the Compliance Officer during a desk audit or a field audit. The CAP gives a provider the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a corrective action to address the findings and observations to ensure future billing and/or documentation compliance with Health Alliance.

Upon receipt of the corrective action plan, the Health Alliance Compliance Officer or designated staff will review the submitted CAP and determine whether the specific plan for corrective action for each audit finding/observation meets the requirements for approval. Health Alliance will provide a letter of acceptance or denial to the provider based upon the submitted CAP.

Health Alliance may deny a submitted CAP if it:

- Fails to address the specific findings/observations.
- Fails to provide a specific plan for corrective action for each deficiency;
- Contains argument or refutation of findings/observations;
- Fails to identify the person(s) responsible for implementation; or
- Fails to identify target dates, including implementation and completion dates.

A follow up review may be conducted after the CAP is accepted to ensure compliance and implementation of the CAP. Any follow up reviews must show adequate corrections of the deficiencies or monetary recoupment and/or termination of your contract with referral to an appropriate government agency could occur.
HIPAA Privacy Policy for Use, Protection and Disclosure of PHI

Health Alliance (covered entity) complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Privacy Rule ensures a patient’s protection of privacy without hindering his or her access to quality health care.

As a health care provider (covered entity) you are required to comply with the HIPAA Privacy and Security Rules. As a contracted provider of Health Alliance for our Medicare Advantage and Part D plans you are also required to protect member/patient PHI based on the contract provisions, such as you must safeguard the privacy of any information that identifies a particular member; take reasonable precautions to maintain the confidential nature of and to prevent the disclosure of confidential records or information, including medical records, relating to members other than to individuals authorized to receive such information pursuant to valid releases, lawful court orders, lawful subpoenas or in accordance with federal or state laws. If required by law, you are responsible for obtaining and maintaining adequate release of information authorizations from members essential for the administration of benefits under the member’s plan.

As covered entities under HIPAA, we are allowed to use members’/patients’ Protected Health Information (PHI) as allowed by the Privacy Rule and we are allowed to disclose PHI to one another for treatment, payment and certain health care operations activities.

Payment and certain health care operation activities include:

- Submission and receipt of claims for reimbursement
- Billing and claims management
- Health care data processing
- Disclosure and receipt of medical record information for review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges
- Utilization review activities, including preauthorization, concurrent and retrospective review of services
- Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines
- Population-based activities relating to improving health or reducing health care costs
- Protocol development, case management and care coordination
- Contact with health care providers or patient/member with information regarding treatment alternatives
- Review of competence or qualifications of health care professionals and evaluate practitioner, provider or health plan performance
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

If authorization by the member is required before releasing PHI (for example, for mental health records), Health Alliance will obtain a completed and signed form from the member (see form included on next page) and send it to you along with our request for the PHI.

We have provided a copy of our Notice of Privacy Practices which describes how we protect this information.
Even though HIPAA does not require the use of this form for medical necessity review or appeals (except when mental health information is involved), a Provider may receive a copy of this completed authorization form signed by the Member. This occurs when Health Alliance requests medical records from the Provider.

I. Information About the Use and Disclosure of Protected Health Information

I hereby authorize the disclosure and use of my protected health information as described below:

Person(s) or organization(s) providing the information: ___________________________________________

Person(s) or organization(s) receiving/using the information: _________________________________

A detailed description of the specific type of protected health information to be disclosed and/or used (include dates and type of treatment):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The purpose for which protected health information will be disclosed and/or used:

________________________________________________________________________
________________________________________________________________________

If information below is stated above, release is authorized. Please circle Yes or No in the column below.

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<th></th>
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<th>Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or mental health professional.</th>
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<tbody>
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II. Important Information About Your Rights

I have read and I understand and acknowledge the following statements about my rights:

• I may revoke this authorization at any time prior to the expiration date by notifying Health Alliance in writing. However, the revocation will not have any effect on actions taken before the revocation was received.
• If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
• Treatment, payment, eligibility or enrollment will not be conditioned on obtaining this Authorization except as specifically authorized by law.

This Authorization expires one year after the date signed below or upon the following specific date, event or condition:_______________________________________________

III. Signature of Member or Member’s Representative

I accept these terms and authorize the above use and disclosure:

____________________________________  _______________________________________
Member or Member’s Legally Authorized   Witness Signature and Date
Representative’s Signature and Date

______________________________
Printed name of the member or Legally Authorized Representative

If signed by a Legally Authorized Representative, please indicate the relationship to the individual

If a representative signs on behalf of the member, Health Alliance must have a copy of the legal document declaring representation on file.

IMPORTANT NOTICE: Any information disclosed is protected by Federal Protection Rules (42 CFR Chapter I, Part 2) and State Mental Health Protection Laws and is prohibited from further disclosure unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal Rules restrict use of the information to criminally investigate or prosecute any member receiving treatment for alcohol or drug abuse.
Health Alliance Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of this notice: April 14, 2003

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal, and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health.

This notice describes the way we may use and disclose information about your health to carry out treatment, payment and health care operations and for other purposes as permitted or required by law. It also describes your rights and duties regarding the use and disclosure of medical information.

INFORMATION THAT THIS NOTICE APPLIES TO
This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that could only be used to identify you.

We collect such personal information as name, address, telephone number, Social Security number, age, sex and medical diagnosis to coordinate medical care. This information is obtained from member enrollment forms, member surveys and claims.

OUR LEGAL RESPONSIBILITIES
• We are required to maintain the privacy of your medical information.
• We are required to provide this notice of privacy practices and legal duties regarding medical information to anyone who asks for it.
• We are required to abide by the terms of this notice until we officially adopt a new notice.
• We will not sell your protected health information.
• We will not use or disclose genetic information for underwriting purposes.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION
The following categories describe different ways that we may use and disclose protected health information without your authorization. For each category, we give some examples of uses and disclosures. Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of these categories.

Treatment: We do not provide medical treatment or services. We may disclose information about your health to a physician or health care professional involved in making a decision that could affect your care. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription contradicts prior prescriptions.

Payment: We use and disclose information about your health to determine eligibility for benefits and payment of claims for medical treatment or services. For example, we may disclose information to your health care provider to verify coverage for medical treatment or services. Likewise, we may share medical information with a health care provider to assist in billing or filing claims for payment of treatment and services, including third-party liability claims and coordination of benefits. We may also send you information about claims we pay and claims we do not pay (called an “explanation of benefits”) for you and your covered dependents. Under certain circumstances, you may request to receive this information confidentially.

Health Care Operations: We may use and disclose your medical information for activities that are necessary for our HMO and health insurance operations. These uses and disclosures are necessary for our business and to make sure you are receiving quality services. Some examples of how we may use and disclose information about your health include: case management and care coordination conducting quality assessment and improvement activities such as...
Compliance Program

outcomes evaluation and development of clinical guidelines; underwriting, premium rating and other activities relating to coverage; submitting claims for stop-loss or reinsurance coverage; conducting or arranging for medical review; fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. Some examples of business associates are our lawyers, auditors, accrediting agencies, consultants, pharmacy benefit managers, collection agencies and printing and mail service vendors. Our business associates are required to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your authorization or without allowing you to object or agree to the use or disclosure.

Legal Requirements: We may use and disclose your medical information when we are required to do so by law. This includes disclosing your protected health information to a government health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure. For example, we may be required to disclose your medical information, and the information of others, if we are audited by the Illinois Department of Insurance. We will also disclose your medical information when we are required to do so by a court order or other judicial or administrative process.

To Report Abuse: We may disclose your medical information when the information relates to abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting or with your permission.

Law Enforcement: We may disclose your medical information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness, missing person or in connection with suspected criminal activity. We may disclose protected health information in response to court orders or in emergency circumstances related to a crime. We may also disclose your medical information to a federal agency investigating our compliance with federal privacy regulations.

Family and Friends: Unless you object or law prohibits it, we may disclose your medical information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim or what benefits you are eligible to receive.

To Avert a Serious Threat: We may disclose your medical information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Health Benefits and Services: We may use your medical information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers’ Compensation: We may disclose medical information to the extent authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs that provide benefits for work-related injuries and illnesses.

Plan Sponsors: We may disclose medical information about you to your plan sponsor to carry out plan administration functions the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended.
ORGANIZED HEALTH CARE ARRANGEMENTS
We may share information that we have about you within our organization and with Carle Physician Group, Carle Foundation Hospital and their affiliates; and with Springfield Clinic, Memorial Medical Center and their affiliates for purposes of health care operations under an organized health care arrangement. Sharing information enables us to:

- Determine our financial risk
- Resolve quality of care complaints
- Arrange for medical and clinical peer review
- Improve our methods of payment or coverage policies
- Arrange for legal services
- Perform utilization management services

YOUR RIGHTS
The following describes your rights regarding the protected health information we maintain about you. If you want to exercise your rights, please contact a member of our Medicare Services Department, who will give you the necessary information and forms for you to return to the address listed under “Whom to Contact” at the end of this notice.

Authorization: We may use and disclose your medical information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your medical information for any other reason without your authorization. If you authorize us to use or disclose your medical information, you have the right to revoke the authorization at any time. You may not revoke an authorization for us to use and disclose your medical information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization. We will receive an authorization from you for certain marketing activities.

Request Restrictions: You have the right to request that we restrict uses and disclosures of your medical information that we use for treatment, payment and health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment of your care, like a family member. We will consider your request, however, we are not required to agree to a restriction. We cannot agree to restrict disclosures that are required by law.

Receive Confidential Communications: If our normal communication channels could endanger you, you have the right to request that we send communications that contain your medical information by alternative means or to an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests to the extent the request specifies an alternative location and allows us to continue to pay claims.

Inspect and Copy: You have the right to inspect the medical information that we maintain about you in our records and to receive a copy of it. This right is limited to information about you that is used to make decisions such as claims, payment and enrollment records. Under state and federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceedings. To inspect your records or to receive a copy, send your written request to the address listed under “Whom to Contact” at the end of this notice. We may charge a fee for the cost of copying and mailing the records. We will respond to your request within 30 days.

We may deny you access to certain information if it would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, we will explain how you may appeal the decision.

Amend: You have the right to request that we amend your medical information for as long as we maintain such information if you believe that the information is incorrect or incomplete. This right is limited to information about you that is used to make decisions such as claims, payment and medical case management records. Your written request must include the reason or reasons that support your request. We will respond to your request in writing within 30 days.
Compliance Program

days. We may deny your request for an amendment if we determine the record that is the subject of the request was not created by us, is not available for inspection as specified by law or is accurate and complete.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures of your medical information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; disclosures made with your authorization; communications with family and friends; disclosures made for national security or intelligence purposes; disclosures to correctional institutions or law enforcement officials; or disclosures made prior to April 14, 2003. We will provide the first list of disclosures you request at no charge. A reasonable, cost-based fee may be imposed for each subsequent request. You must tell us the time period you want the list to cover. If a breach of your protected health information occurs, we will notify you within 60 days.

Receive a Paper Copy: You have the right to obtain a paper copy of this notice at any time.

Complaints: You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with our Medicare Services Department. (See “Whom to Contact” at the end of this notice.) You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services. We will not take any retaliation against you if you file a complaint.

Maintaining Confidentiality of Member Information: The security of our members’ personal information is very important to us. Member information is never sold to anyone, for any purpose. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your privacy.

All Health Alliance employees are educated on our standards and are required to sign a confidentiality and security agreement annually. Any employee found to be in violation of our privacy practices is subject to disciplinary action. Employees are encouraged to report violations of confidentiality using the Health Alliance compliance hotline.

CHANGES TO THIS NOTICE
We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any medical information that we already have, as well as to medical information we receive in the future. Before we make any change in the privacy practices described in this notice, we will mail a revised notice to you within 60 days of the effective date.

WHOM TO CONTACT
You may contact a member of our Medicare Services Department at 1-800-965-4022 or TTY/TDD 711 or 1-800-526-0844 (Illinois Relay) for the hearing impaired. Representatives are available from 8 a.m. to 8 p.m. Monday through Friday. You may also write to the address below for the following requests:

• For more information about this notice
• For more information about our privacy policies
• If you want to exercise any of your rights, as described in this notice
• If you want to request a copy of our current notice of privacy practices

Health Alliance Medicare
Medicare Services Department
301 S. Vine St.
Urbana, Illinois 61801

This notice is also available on our website at: HealthAlliance.org
TC3 Overpayment Recoupment Requests

The Centers for Medicare & Medicaid requires all Medicare Advantage plans to make a determined effort to prevent, detect and correct health care fraud, waste and abuse. Health Alliance has selected TC3 Health (an Emdeon Company) as a partner in our ongoing effort.

TC3 performs overpayment analysis on all Health Alliance claims. Provider offices may see an increase in recoupment requests (based on national coding standards) and an increase in medical record requests from Health Alliance or TC3. The requests are based on audits performed on billing errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The audits are performed following government and industry rules, regulations and policies governing health care claims. The findings within the letters are based upon nationally recognized and accepted sources, including American Medical Association CPT Guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

Providers may appeal the findings in the recoupment requests by following the complaints and appeals process in the Appeals Process section of this manual.
Introduction

Health Alliance has contracted with the Centers for Medicare & Medicaid Services (CMS) to offer Health Alliance Medicare HMO 20, Medicare HMO 20Rx, Medicare HMO Basic, Medicare HMO BasicRx, Medicare PPO 10, Medicare PPO 10Rx, Medicare PPO 30, Medicare PPO 30Rx — Medicare Advantage plans for Medicare-eligible individuals. To our beneficiaries, they consider these plans Medicare. Therefore, contracted providers should also consider us to be Medicare for billing and coverage purposes. To enroll in a Medicare HMO or PPO plan, a Medicare beneficiary must have both Medicare Part A and Part B, must live in the service area and must not be diagnosed with End Stage Renal Disease (permanent kidney failure that requires regular kidney dialysis or a transplant to maintain life).

Health Alliance Medicare HMO and PPO beneficiaries receive a written health screening during the first month of enrollment. Beneficiaries are designated as “well,” “moderate” or “at-risk.” Case managers will work with the PCP to develop a plan of care for at-risk beneficiaries or to coordinate a preventive care schedule for beneficiaries identified as moderate or well.

As a side note, we also offer a Stand-Alone Prescription Drug Plan and Medicare Supplement plans A, C, F and N.

**Medicare HMO**

Health Alliance Medicare HMO 20, HMO 20Rx, HMO Basic and HMO Basic Rx beneficiaries may only see contracted providers at offices within the service area (see service area map). Contracted providers with offices both in and out of the service area must be mindful of this requirement and not see Health Alliance Medicare HMO beneficiaries out of the service area.

The plan structures are similar to a traditional HMO product and allow the beneficiary to receive the comprehensive benefits provided by HMOs, including routine physicals, mammograms, prostate exams and routine vision care. Beneficiaries must receive their care within the contracted network of providers to be eligible for benefits. Care received outside of the designated network (except in emergency care, urgently needed care and out-of-area renal dialysis) must have prior written approval from a Health Alliance medical director. Travel benefits are available for certain continuity of care services when the beneficiary will be out of the service area for up to 90 consecutive days. The request for Travel Care benefits must be coordinated by the PCP prior to the member leaving the service area.

Health Alliance Medicare HMO beneficiaries choose a PCP from Adult Medicine or Family Practice (or, in some cases, Pediatrics). The PCP is responsible for coordinating the beneficiary’s health care and directing specialty care services. **Please note: the network of providers for Health Alliance Medicare HMO varies from the Health Alliance commercial network, so it is vital to consult the Medicare HMO provider directory when making referrals for specialty care.** Selected services may require preauthorization from the Health Alliance Medical Management Department. The preauthorization is obtained by the ordering physician’s office.

**Medicare PPO**

Health Alliance Medicare PPO beneficiaries may seek services from any physician, specialist or hospital, regardless of whether the provider is part of the Health Alliance Medicare network or not. However, if a beneficiary visits a provider outside our network, the beneficiary may have to pay more for the services received and may have to follow special rules for coverage.

**Please note: the network of providers for Health Alliance Medicare varies from the Health Alliance commercial network, so it is vital to consult the Medicare provider directories when making in-network referrals for specialty care.** Selected services may require preauthorization from the Health Alliance Medical Management Department. The preauthorization is obtained by the ordering physician’s office.

Copayments are required at the time of appointment regardless of the beneficiary’s benefit plan. The copayment varies depending on the point of service.
Counties in the Health Alliance Medicare HMO Nebraska/Iowa service area include: Douglas, Pottawattamie and Sarpy.
Counties in the Health Alliance Medicare HMO Washington service area include: Chelan, Douglas, Grant and Okanogan.
Health Alliance Medicare Staff

**Member Services**
Health Alliance has a Member Services staff dedicated to Health Alliance Medicare beneficiaries.

**Member Services Representative**
A Member Services Representative is trained to answer any questions members have about Health Alliance Medicare. From lost ID cards to changing doctors, all calls are documented and acted upon by the Member Services Representative. Member Services Representatives are available toll-free from 8 a.m. to 8 p.m., Monday through Friday. Calls are returned within one business day if messages are left on voicemail.

**Community Representative**
The Community Representative establishes strong relationships and lines of communication with all community, private and public organizations dealing with the Medicare population. He/she encourages and creates new opportunities to work collaboratively with these organizations and others to promote our common desire to serve the Medicare population. He/she works closely with our internal staff to ensure that our promotional and sales activities are appropriate, understandable and successful based on feedback from external contacts and coordinates, attends and hosts community meetings on behalf of Health Alliance Medicare Products. Also, he/she organizes seminars and joint promotional events.

**Case Manager**
For members at risk for serious medical complications, Health Alliance offers Case Management with experienced registered nurses called case managers. These nurses work with selected Health Alliance Medicare beneficiaries to assess, coordinate and authorize services, and note any changes in health status. The nurses educate members on their medical condition and lifestyle changes that could impact or slow down the progression of the disease. For more information on Personal Health Coordination, please refer to the Medical Management section of this manual.
The Quality and Medical Management (QMM) Program integrates the primary functions of Quality, Medical Management and Pharmacy. These departments work in tandem to establish, coordinate and execute a structure to support Health Alliance members/enrollees as they work to improve their health and assess and evaluate the care and service provided. Note: the following are used interchangeably throughout the document; Health Alliance and Health Alliance Medical Plans; and case and care management.

**DEFINITION OF QUALITY**
- Clinical quality is defined as minimum variation from evidence-based practice or expert consensus.
- Service quality is defined as meeting or exceeding the valid service requirements of our customers.

**PURPOSE**
Quality Improvement (QI) at Health Alliance is an integrative process of continuous assessment and monitoring that strives to improve care and service provided to Health Alliance members/enrollees for all products. Activities are monitored according to a variety of quality indicators and regulatory requirements as outlined in the annual QI Plan. These indicators assess the healthcare programs delivered within the Health Alliance system. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members/enrollees by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. Components of the QMM Program include all products and plan types for Commercial HMO/POS, Commercial PPO, Medicare HMO, Medicare PPO, SNP, MMAI, SPD and FHP unless otherwise specified. The Quality and Medical Management Department is committed to ensuring that the care delivered to our members/enrollees is of the highest “value.” Value = Quality + Service/Cost.

**GOALS**
The goals of the Health Alliance QMM program include:
- A. Identify special needs of the target populations served through annual population assessment data.
- B. Establish standards of clinical care and service for the target populations and measure performance outcomes adhering to NCQA, HPMS, CMS, and State and health plan requirements.
- C. Identify opportunities to enhance clinical care and service for the target populations.
- D. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service.
- E. Measure the effectiveness of interventions and implement actions as needed to improve.

**OBJECTIVES**
The objectives of the Health Alliance QMM program include:
- A. Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for the target populations.
- B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful structure and process measures in the QMM program.
- C. Facilitate a partnership between practitioners, providers, members/enrollees, and Health Alliance for the purpose of maintaining and improving plan-wide services.
- D. Annually measure access, availability, and trends in member/enrollee satisfaction for improving service.
- E. Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers.
- F. Involvement of designated behavioral health care practitioners to address behavioral health issues, including continuity and coordination of care, preventive health, clinical practice guidelines, appropriate triage and referral, customer service, clinical care including pharmaceutical management and all aspects of the QMM program. Health Alliance does not have a centralized triage and referral process for behavioral health services.
- G. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member/enrollee and practitioner appeal rights, and appropriate handling of denials of service. Through the UM process, each case is evaluated against established medical criteria to determine medical necessity. In the case of Medicare plans, the reviewer complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment (when applicable) are reviewed when applying criteria. Department policies and procedures further define these processes in detail.
- H. Measurement of the effectiveness of the model of care for designated populations.
I. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety including medication therapy management data, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.

J. Develop and maintain a credentialing and recredentialing program for individual practitioners and provider organizations that adhere to federal and state regulations, as well as standards for accreditation.

K. Provide access to information about patient safety to members/enrollees and practitioners through our website while encouraging accountability for patient safety with contracted providers through our Adverse Events and Quality of Care processes.

L. Assess cultural and linguistic needs of member/enrollee population at least annually and report findings to the Members Rights and Responsibilities/Quality Improvement Committee. Annual assessment includes evaluation of CAHPS® and new member/enrollee survey demographic data, Language Line translation requests for oral translation services, complaint data, CACTUS credentialing system data for provider language spoken, CCMS case management cultural need responses, and data provided by Health Alliance’s four major provider systems. Health Alliance also monitors CMS CLAS County Data report based on American Community Survey (ACS) data published by the U.S. Census Bureau which provides notification to health plans meeting the 10% or more threshold of the same non-English language by county.

M. Provide members/enrollees with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member/enrollee information and records.

N. Develop and promote preventive health standards, family planning services and programs to encourage members/enrollees and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.

O. Provide an appeals process designed to protect the rights of the member/enrollee, physician and hospital as fully as possible. Ensure that any member/enrollee, provider or practitioner who is affected by an adverse determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.

P. Establish standards and processes for maintenance and oversight of delegated activities, if applicable.

Q. Establish an annual QMM Plan that describes specific activities undertaken each year to address the components of the QMM program.

R. Annually review the program activities to determine effectiveness and focused priorities for the coming year. The QMM department prepares an annual evaluation that is reviewed and approved by the Health Alliance Vice President and Senior Medical Director of Medical Management and Quality, Executive Director of Quality and Medical Management and the Quality Improvement Committee. The annual evaluation contains a summary of the year’s program activities, an assessment of the effectiveness of the various components of the program as well as recommended program modifications and activities planned for the coming year are included. The annual assessment of effectiveness includes a review of the SPD/MMAI/SNP/FHP Integrated Care Team model and Model of Care. The annual evaluation highlights significant changes in the operation of the Quality Management, Medical Management, Pharmacy and Case and Utilization Management Programs based on review and recommendations from QMM leadership. Member/Enrollee and practitioner satisfaction with program activities is assessed as part of the evaluation. The impact of activities is reviewed by using the program evaluation to identify opportunities for improvement and to revise the programs as needed.

PROGRAM SCOPE
The scope of the Health Alliance QMM program is designed to fulfill the goals and objectives of the program, while efficiently utilizing resources to promote and enhance integration of quality activities internally (within Health Alliance) and externally with practitioners, providers, members/enrollees, employers, state and federal agencies, and appropriate parties. The scope of the QMM program includes, but is not limited to:

A. Clinical Care
   1. preventive health activities
   2. family planning services
   3. clinical quality improvement activities
   4. clinical management criteria and guidelines
   5. disease management
   6. credentialing and recredentialing
   7. inpatient care review for inpatient, surgical and behavioral health care admissions
   8. discharge planning
   9. preauthorization review for medical necessity
   10. case management, including complex case management

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Quality Management

B. Service
1. Member/enrollee complaints and appeals
2. Trends in member/enrollee dissatisfaction/satisfaction (including CAHPS® surveys)
3. Appointment and afterhours access monitoring
4. Practitioner availability monitoring
5. Telephone access
6. Written and verbal communications with members/enrollees
7. Concurrent review

C. Behavioral Health Services
1. Preventive health
2. Mental health and substance abuse quality improvement activities
3. Behavioral management criteria and guidelines
4. Telephone and appointment access monitoring
5. Credentialing and recredentialing
6. Utilization management
7. Care transitions

D. Patient Safety
1. Continuity and coordination of care between practitioners and providers
2. Tracking and trending of adverse events
3. Evaluation of clinical care against aspects of evidence-based guidelines that improve safe practices by detecting under- and over-utilization
4. Implementation of health management systems that support timely delivery of care
5. Medication management evaluation through case management program

STRUCTURE OF PROGRAM
The Quality and Medical Management Program provides a comprehensive structure to identify, evaluate and improve clinical care and service provided to members/enrollees individually and collectively. The Health Alliance Board has designated the day-to-day accountability of the quality and medical management program to the Health Alliance Vice President and Senior Medical Director of Medical Management and Quality and Executive Director of Quality and Medical Management with reporting accountability to the Quality Improvement Committee (QIC). Subcommittees, workgroups and operational teams of the QIC provide a focus on initiatives involving quality improvement such as members’ rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments and individual staff members/enrollees have key roles and responsibilities in the QMM program.

MEDICARE ADVANTAGE/SPECIAL NEEDS PLAN (SNP)
In addition to objectives, scope and program structure previously described, the following are specific to the Health Alliance Medicare Advantage/SNP enrollees, defined as a Medicaid subset D-SNP:

1. Implement chronic care improvement programs (CCIP) through methods that identify enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in the program. In addition, establish mechanisms for monitoring these enrollees that are participating in the chronic care improvement program. The program also addresses additional populations identified by CMS based on a review of current quality performance.

2. Quality improvement projects (QIP) that can be expected to improve health outcomes, enrollee satisfaction, and addresses areas identified by CMS.
   a. The projects are specific initiatives that address clinical and non-clinical areas and involve measurement of performance, system interventions including the establishment or alteration of practice guidelines, improving performance and systematic and periodic follow-up on the effect of the intervention.
   b. The projects assess performance under the plan use quality indicators that are objective, clearly and unambiguously defined, and are based on current clinical knowledge or health services research.
   c. The performance assessments on the selected indicators are based on systematic ongoing collection and analysis of valid and reliable data.
   d. Interventions identified in the annual work plan strive to achieve demonstrable improvement and improvement is documented in the annual evaluation.
   e. Each QIP project status and results of each project are reported to CMS as requested.

3. Encourages providers to participate in CMS and Health and Human Service (HHS) QI initiatives.

4. Contracts with approved Medicare CAHPS® vendor to conduct the Medicare CAHPS® survey.

5. Complies with and monitors the activities reflected in the Medicare Star Rating strategy to be consistent with the six priorities in the National Quality Strategy including making care safer by reducing harm caused by

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Quality Management

the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models.

6. Complies with CMS requirements for Medication Therapy Management programs. The goal is to optimize therapeutic treatment of specified chronic disease states by increasing compliance and providing education to enrollees and prescribers.

a. Health Alliance contracts with Medication Management Systems, Inc. to perform the Medication Therapy Management functions.

b. Health Alliance policy 1233 – Medicare D Medication Therapy Management Program outlines the identification of beneficiaries, intervention and reporting processes and policy 1753 for Medicare D Reporting Requirements-Medication Therapy Management further outlines reporting.

c. Health Alliance provides Medication Management Systems, Inc. eligibility data files as well as beneficiary plan start/end dates. Members are selected based on criteria identified within the policy. All eligible members are included unless the member chooses to opt out of participation.

d. Medication Management Systems, Inc. provides services including determination of eligibility, telephonic CMR, medication action plan, personal medication list, targeted medication review and other interventions identified in the policy. Health Alliance reviews all interventions and provides feedback and further education/assistance as necessary.

e. Health Alliance stratifies members selected for MTMP into case management per chronic disease state.

f. CMS data validation standards are used to validate accuracy of reporting data. Data is uploaded to CMS annually via HPMS.

To support CMS regulations, Health Alliance maintains a health information system that collects, integrates, analyzes and reports data necessary to implement its QI program:

• Health Alliance has policies and procedures in place on the requirements for reporting data to CMS. Updates to the Reporting Requirements are reviewed upon publication and updates to policies, procedures and systems are completed.

• Health Alliance collects data on the following:
  a. Provider characteristics – via Visual CACTUS Credentialing System for provider and the MC400 as the primary member system of record for member characteristics.
  b. Services furnished to members – via McKesson Compliance Reporter and Risk Manager (HEDIS®*), CAHPS®* survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.
  c. Data to guide the selection of quality improvement project topics and meet the data collection requirements for quality improvement projects – via McKesson Compliance Reporter and Risk Manager (HEDIS®*), CAHPS®* survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.

• Health Alliance ensures that information and data received from providers are accurate, timely and complete – via MC400 Claims processing system and MedImpact PBM.

• Health Alliance has information systems that integrate data from various sources, including member concerns and complaints – via SalesForce.

• Health Alliance has a formalized process to analyze data – via McKesson Compliance Reporter and Risk Manager (HEDIS®*), Statistical package for Social Sciences (SPSS), and Access data bases as needed, as reported to QIC.
  a. Health Alliance addresses identified deficiencies in reported data through provider feedback or other corrective action – via QMM Program through McKesson Compliance Reporter (HEDIS®*) and Risk Manager, ambulatory and inpatient reviews.
  b. Health Alliance complies with HIPAA and privacy laws and professional standards of health information management through the Compliance Committee.

• Health Alliance conducts a pre-assessment on the Part C measures and has checks and balances in place for data submission. Corrective actions are put into place for all findings from the data validation audit or CMS notification.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Quality Management

Formal evidence of the impact and effectiveness of the QI program is documented in the quality and medical management annual evaluation. The evaluation includes measurement tools required by CMS and is made available to CMS to enable beneficiaries to compare health coverage options and select among them based on quality and outcomes measures.

The process of integrating the quality improvement initiatives with various Health Alliance departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. These individuals support the development and continuous evaluation of the QMM Program, through the plan, do, study and act cycle. It is the primary responsibility of the QMM Department to diffuse quality initiatives throughout the organization.

KEY PERSONNEL

a. **Vice President and Senior Medical Director for Medical Management and Quality** provides medical leadership for all Health Alliance products in all service areas and oversees the successful implementation of medical management, quality and pharmaceutical programs. The position chairs the Quality Improvement Committee, Medical Director Committee, Adverse Events Committee, Medical Policy Committee and Behavioral Health Workgroup and participates as a member of the Pharmacy and Therapeutics, Compliance, Community Stakeholder and Government Programs Workgroups. All Medical Directors report to the Vice President and Senior Medical Director for Medical Management and Quality and to the Executive Director of Quality and Medical Management for administrative functions.

b. **Medical Directors** are key resources for the quality and medical management team. Medical Directors are represented on the Quality Improvement Committee and obtain feedback on quality and medical management and pharmacy initiatives throughout the Health Alliance network. Physicians and pharmacists make all UM denial determinations for medical necessity through daily reviews for medically necessary services at all levels and appeal reviews, they are key to the following areas:

- **Vice President and Senior Medical Director of Regional Partner Relationships** is an emergency room physician and a member of the Quality Improvement Committee, Medical Directors Committee, Medical Policy Committee, MRRRC, Star Strategic Plan Workgroup and Government Programs Workgroup. He provides oversight for the Health Alliance joint venture medical directors, devoting 50% of his time to Health Alliance and 50% as an Emergency Department regional outreach physician at Carle.
- **The Senior Medical Director is a Family Practice physician by training, and a 100% medical director.** He participates in the Medical Policy Committee, Quality Improvement Committee, Credentialing Committee and Medical Director Committee and leads the preauthorization review process, medical policy development and annual review, tech topic reviews, out of area concurrent review, and supports the CCMS system enhancements and embedded criteria, including the provider portal link to Clear Coverage.
- **Two Regional Medical Directors are Family Practice Physicians. One is an 85% medical director for the Bloomington/Peoria and surrounding markets. He chairs the Credentialing Committee, participates in the Adverse Event Committee, Medical Directors Committee and OSF Joint Venture team, leads acute and non-acute concurrent review activities and interrater reviews. The other leads initiatives in the Springfield market and chairs the Pharmacy and Therapeutics Committee, participating in the Credentialing Committee, Needs Assessment Committee, and the Springfield Joint Venture team. Additional Medical Directors provide day-to-day support at least 20% time for medical necessity reviews. Their specialties include Allergy, Emergency Medicine, Pediatrics and Otolaryngology/Head and Neck Surgery.

c. **Executive Director of Quality and Medical Management** provides oversight for the quality and medical management department and is a key resource to the model of care for the SPD/MMAI/SNP population. Responsible for identifying, implementing, monitoring and evaluating quality and medical management activities to improve care and service provided to all Health Alliance members/enrollees. Responsible for overseeing the areas of credentialing and re-credentialing for all providers (individual and facilities); wellness; enhance Joint Venture and community partnerships; member/enrollee appeal and grievance monitoring to meet regulatory agency requirements; clinical guidelines for acute, chronic, preventative and behavioral health services; population-based disease management programs with the goal of improving health outcomes; case management to ensure engagement and improvement in quality of life; utilization management to focus on reducing medical spend while maintaining or improving quality; and ensuring appropriate document and reporting systems are utilized to maximum efficiency.

d. **Pharmacy Director** is responsible for drug formulary design and development, implementation and risk management to improve quality, control cost and contain costs. Responsible for the supervision of the pharmacy network, pharmacy staff, pharmacy related contracting and pharmacy benefit manager. Evaluates and implements interventions that address clinical, administrative, financial and regulatory challenges involved in managing pharmaceutical costs and utilization.
c. **Contracting and Provider Services Director** oversees the contracting and provider services department. Responsible for the overall direction and coordination of Network Development, Contracting and Provider Relations functions. Duties include planning, directing, organizing, controlling, and evaluating the implementation of strategic and tactical plans that ensure effective provider interactions and network development, and their continued viability to the organization.

d. **Utilization Management Manager**, for inpatient and outpatient services, is a registered nurse who oversees the utilization management activities for all products. She oversees the preauthorization process using established criteria to determine coverage, ensures that questionable cases or any potential denials based on medical necessity are forwarded to a Medical Director for review, ensures utilization management coordinators determine denials based on benefits only; and support the Intake Coordinators who are the front line staff for the preauthorization process. Three senior nurse coordinators report to the manager, one leads inpatient and two lead outpatient activities.

e. **QMM Data Reporting Manager** ensures the successful and accurate completion of all HEDIS® reporting for all products and the impact on the results to NCQA; develops innovative solutions around disease management reporting and links all affected systems. Manages the HEDIS® Supervisor, and key QMM staff for data reporting and system operations for the QMM department.

f. **Corporate Quality Manager** develops, implements and monitors a corporate quality improvement plan that includes interventions to improve care and service for all members/enrollees, including expansion areas and products. The position manages applicable staff as well as collaborates with and supports the Data Reporting staff around HEDIS® and Star ratings with the goal of attaining excellent NCQA accreditation for all products and 5 Star rating for Medicare Advantage products.

g. **Accreditation and Credentialing Manager** oversees the day-to-day credentialing and re-credentialed for all practitioners and providers, as well as manages the delegated credentialing program. Key contact to coordinate NCQA activities and facilitates completion of NCQA onsite activities.

h. **Case and Disease Management Manager** is a registered nurse and certified rehab counselor who oversees the integration of case and disease management to ensure a focus on the continuum of care. She leads the case management team, which consists of senior case managers, nurses, social workers and administrative staff. Designated case managers lead an integrated care team (ICT) to address specific needs and obtain input from the enrollee’s primary care physician. In addition, a person centered Care Plan is developed and maintained for designated enrollees.

i. **Member Relations Manager** oversees the staff and management of the appeals process, DOI complaints, ERO reviews and Peer reviews for all products and service areas.

j. **QMM Vendor & Medicaid QI Specialist** implements and maintains a Medicaid focus for the corporate quality and medical management program that includes vendor management for QMM core processes. Participants in QI Operational Teams as well as ensures completion and monitoring of the Medicare/Medicaid Duals CCIP and QIP projects and contributes to Medicaid HEDIS® and NCQA preparation.

k. **Wellness Administrator** develops, implements and oversees all wellness activities internal to Health Alliance as well as offerings and supporting employer groups.

l. **Quality and Health Management Services Coordinators**, through accountability for assigned quality initiatives, facilitate solutions to improve care and service through population based disease management and patient safety programs, HEDIS® data collection, complete tasks that support activities defined in the QI work plan and prepare routine reports to the Quality Improvement Committee (QIC).

m. **Star Coordinators** focus on improving star rating measures. Oversees population disease management programs for all populations and Medicare specific NCQA/CMS requirements.

n. **Systems and Operations Specialist** is the technical resource for the McKesson products that support the quality and medical management department. Primary responsibilities include the analysis, testing and the integration of the organization’s software and information systems as it relates to quality and medical management functions. Ensures supplemental products/upgrades within the system, released for production, contain no identified defects. Provides technology expertise to the department and collaborates with other departments for data collections and system upgrades and maintenance. Functions as a liaison and resource to the IT Department related to medical management systems and software.

o. **Utilization Management Coordinators** include inpatient and outpatient nurses. Outpatient focus is on preauthorization of designated medical services and procedures. Inpatient Coordinators perform concurrent review, with a key focus on discharge planning, in the inpatient acute setting and at non-acute skilled nursing facilities. Retrospective reviews are conducted within each area, as appropriate. Established clinical criteria are used to determine coverage based on medical necessity. Questionable cases or potential denials based on medical necessity are forwarded to a Medical Director for review. Utilization Management Coordinators (previously called medical management coordinators) may determine denials based on benefits only.

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Quality Management

r. **Outpatient Case Managers** facilitate care transitions and complex member/enrollee needs through motivational interviewing techniques and approved scripting. An initial clinical assessment, screening for changes in health status, care transitions, and coaching and monitoring behavior changes for improved self-management are the performance expectations. Members/enrollees are also reminded about necessary testing and follow-up care as determined by clinical guidelines. Patient information sources include medical and pharmacy claims, medical record documentation, discussion with appropriate physicians and information gleaned from the member/enrollee.

s. **The Communications Specialist** is dedicated to quality management to provide consultation for material presentation and coordinate material distribution, as needed.

**TECHNICAL RESOURCES/SYSTEMS**

There are a number of technical resources/systems available to support and implement the QI program:

a. **McKesson Vitals Platform** is a McKesson system that provides, condition identification, program identification/work list, risk levels/risk profile, identification of gaps in care, system alerts and messaging capabilities to support medical management services including utilization management, case management, disease management, management of members/enrollees at risk (complex case management) and documentation of appeals. The system allows evaluation of care management by tracking and measuring goals, interventions and outcomes. Health Alliance migrated to the McKesson Vitals platform from the McKesson CCMS system in the fall of 2013.

b. **InterQual®** is embedded in CCMS and is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness. The following guidelines are used:
   - **Inpatient Services**
     - InterQual® Level of Care: Acute Criteria, Adult
     - InterQual® Level of Care: Acute Criteria, Pediatric
     - Prest & Associates, Inc. Review Criteria – Mental Health
   - **Outpatient Services**
     - InterQual® Care Planning: Procedures Criteria, Adult and Pediatric
     - InterQual® Care Planning: Imaging Criteria, Adult and Pediatric
     - InterQual® Care Planning: Molecular Diagnostics
   InterQual® is a nationally respected vendor with clinical criteria based on best practice, clinical data and medical literature. Prest & Associates, Inc. is a nationally respected independent review organization that provides behavioral health criteria along with consultation and review services with board certified physicians in mental health and substance abuse. ASAM guidelines are a nationally accepted standard of care for the treatment of substance abuse disorders.

Where vendor guidelines are incomplete or absent, internal medical policies that reflect current standards or medical practice are developed by the Medical Director Committee and reviewed by the Medical Policy Committee. All Health Alliance criteria and medical policies are reviewed annually to determine whether updates/revisions are warranted. The designated Senior Medical Director and the medical management project coordinator receive and research all requests for policy revisions and for new policy development. Annual criteria reviews are conducted through the Medical Directors Committee and Medical Policy Committee as indicated. Coordinators utilize the medical policies to evaluate medical necessity and authorize services if appropriate. Medical Technology reviews are performed on new technologies to ensure that the Health Plan is staying current with the latest standards of care. Medical necessity reviews beyond the scope of current coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each members/enrollee’s clinical status and assessment of the local delivery system. Clinical Peers are used as needed. Medical Directors and Coordinators are evaluated at least annually for consistency of applying criteria, and corrective actions are implemented when needed.

c. **McKesson Risk Manager** is an integrated performance platform that enables better management to reduce medical management costs and improve physician efficiency and quality profiling.

d. **McKesson Compliance Reporter** is used to gather and report HEDIS®**. This includes data reported annually to NCQA, as well as at the provider and employer levels annually and quarterly. The system integrates with VITAL and Risk Manager.

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Quality Management

c. MC400 - Managed Care 400 is a claim processing system from OAO Healthcare Solutions that retains member/enrollee eligibility information, applies provider contract and payment terms, and adjudicates claims based on specific rules established for employer benefit packages.

d. PBM - Pharmacy Benefit Manager MedImpact for Medicare Advantage and Catamaran for the Commercial and SPD/MMAI populations offers customized products and uses an evidence-based approach to manage costs.

e. Visual CACTUS - houses all data for credentialed providers and drives the recredentialing process.

f. Ambulatory Review Database - an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

g. Adverse Events Database - an Access based system developed by Health Alliance staff enables tracking, documentation and reporting of adverse events (never events and sentinel events).

h. Wellness Vendor (Rally) - available to all Commercial & Medicaid Health Alliance member/enrollees and providers free of charge via the Health Alliance/Health Alliance Connect-SNP website. Rally offers web-based wellness programs using current technologies to engage members in improving their health.

i. SPSS - Statistical Package for the Social Sciences allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis.

j. SQL Query Analyzer - Allows users to query data from the data warehouse for reporting or producing mailing lists.

k. Crystal Reports - Allows users to query data from the data warehouse for reporting or producing mailing lists.

l. MCNet - pulls member/enrollee information for the customer service representative from the member/enrollee number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio’s Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring. They are fully integrated with the phones by Cisco Systems.

m. Onyx Customer Center - tracks complaints and feeds into our data warehouse. Reports are run using Crystal Enterprises.

n. Salesforce - a customer relationship management (CRM) service. Broadly, this CRM service is used to manage our customer service, provider relations, and member services. Salesforce also provides easy access to complete member information that is used to ensure more “one and done” service calls. The Custom Cloud allows the creation of powerful custom functionality in Salesforce, which works along with other services like Docusign, Conga, etc. to automate many of our manual processes.

o. CMS - Medicare coverage guidelines. For Medicare plans, national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contracts is used. Individual patient circumstances and the capacity of the practitioner and provider delivery system are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment psychosocial situations, and home environment (when applicable) are reviewed when applying criteria.

p. Storan - software used for Medicare Advantage quality and risk management within Health Alliance.

Descriptions for committees related to the Quality and Medical Management process are available upon request.
Quality Management

National Committee for Quality Assurance (NCQA) and HEDIS®*

In support of our commitment to quality, Health Alliance has voluntarily submitted to reviews by the National Committee for Quality Assurance (NCQA). The NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, preferred provider organizations, new health plans, physician organizations and credentials verification organizations. The mission of the NCQA is to improve the quality of health care delivered to people everywhere. NCQA accreditation evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers and administrative services—to continuously improve health care for its members. At the health plan’s request, NCQA sends a team of trained health care experts to conduct a rigorous on-site survey of the health plan. NCQA uses information from health plan records, consumer surveys, interviews with health plan staff and performance on selected HEDIS® (Healthcare Effectiveness Data and Information Set) measures.

In December 2013, NCQA awarded Health Alliance Medicare Advantage HMO an excellent three-year accreditation. Health Alliance Medicare Advantage PPO received a three-year commendable rating of accreditation.

NCQA’s accreditation standards are publicly reported in five categories:

• **Access and Service:** Do health plan members have access to the care and services they need?
• **Qualified Providers:** Does the health plan assess each doctor’s qualifications and what health plan members say about its providers?
• **Staying Healthy:** Does the health plan help members maintain good health and detect illness early?
• **Getting Better:** How well does the health plan care for members when they become sick?
• **Living with Illness:** How well does the health plan care for members when they have chronic conditions?

Consumers can easily access health plans’ NCQA Accreditation statuses and other information on health care quality at http://reportcard.ncqa.org or by calling NCQA’s Customer Support at 1-888-275-7585.

Health Alliance has identified three major benefits of NCQA Accreditation:

• Preparation for the survey results in a strengthening of Health Alliance’s internal management systems.
• NCQA Accreditation strengthens Health Alliance’s position in the marketplace.
• NCQA Accreditation status is widely accepted and eliminates repetitive state and federal reviews.

HEDIS

HEDIS is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service. It is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare health care quality.

The HEDIS expert panel, the Committee on Performance Measurement, has identified the following “domains” or categories of care for reporting HEDIS*:

• Effectiveness of Care: Measures surrounding prevention, screening and clinical conditions
• Access/Availability of Care: Timeliness of prenatal and postpartum care, availability of primary care providers and specialists
• Satisfaction with the Experience of Care: CAHPS®** survey results
• Use of Services: Frequency of selected procedures, inpatient utilization, etc.
• Health Plan Stability: Total membership
• Health Plan Descriptive Information: Board certification, enrollment information, etc.
• Cost of Care: Relative resource measures for diabetes, asthma, low back pain, etc.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
** CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Audit Requirements
The HEDIS Compliance Audit™ is a two-part program that consists of an overall information system capability assessment coupled with an evaluation of the MCO’s ability to comply with HEDIS specifications. Auditors who are certified by NCQA use standard audit methodologies designed to help purchasers make more reliable comparisons between health plans.

Hybrid Reviews
Plans reporting HEDIS data may draw information from three sources – administrative (i.e., claims), hybrid (combination of claims and medical record review) and survey (direct feedback from the member). The use of hybrid methodology is very time consuming and resource intensive. However, in measures where the specifications and exclusions are complicated, hybrid review often results in improved rates, despite the amount of work involved.

Hybrid review requires the cooperation of a plan’s practitioners. Health Alliance, or its designee, may request an appointment to visit the practitioner’s office to review and copy medical records for members who are part of the sample population for a specific measure. Health Alliance may also contact practitioner’s offices and ask to have specific portions of the medical record sent to our office as proof of compliance with specific measures (i.e., proof of a colonoscopy, etc.)

Access to Services
Health Alliance is committed to providing members with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage underutilization of care. We do not give financial inducements or set quotas for denying care or coverage; nor do we keep statistics identifying individual providers and their denial rates. Utilization decisions made by our medical directors, nurse coordinators, pharmacy coordinators and pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to deny access to services.

As a member of the medical community, Health Alliance understands and respects the need to meet HIPAA requirements and keep medical information regarding patients confidential. As part of the HEDIS review process, we may ask to copy specific portions of the medical record. This is necessary to provide proof of compliance for the measure in question to our auditors. Health Alliance keeps all medical information in confidential files accessible only on a “need to know” basis. No information is released to another party outside of the audit process. If you have any questions or concerns regarding the confidentiality of any documentation provided to our office for quality review purposes, please feel free to contact the Quality Management Director at (217) 337-8129.

HEDIS specifications for the Effectiveness of Care Measures are very explicit. Each measure specifies the ages involved for the measure as well as specific requirements each patient must meet in order to attain compliance. The following pages describe some of the measures Health Alliance reviews and what indicators are required.

Summary of Specifications for HEDIS* Effectiveness of Care Measures
Health Alliance participates in the Healthcare Effectiveness Data and Information Set (HEDIS) audit annually. The following briefly describes some of the HEDIS measures that are included in the annual HEDIS audit for Medicare members. This information is taken from the HEDIS 2014 Narrative and Technical Specifications manual provided by the National Committee for Quality Assurance (NCQA). Additional information can be requested by contacting NCQA at www.ncqa.org, or by contacting the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112.

Remember: As a contracted provider you are expected to cooperate fully with Health Alliance Medical and Quality Management programs, which include access to medical records for these purposes. For example, you may receive requests for medical information related to quality assurance audits from the Quality Management Department annually during HEDIS or other times during the year. Please contact the Quality Management Department with any questions or concerns at 1-800-851-3379, extension 8112.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
*** HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
**HEALTH ALLIANCE MEDICAL PLANS**

Medicare Advantage HEDIS® Measures

Reporting year: 2015  
Measurement year: 2014

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>INDICATORS</th>
<th>NOTES, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adult BMI Assessment¹,²</td>
<td>18 to 74 years</td>
<td>Documented at least every two years in the medical record:</td>
<td>Acceptable documentation for adults includes the BMI value. For patients younger than 19 (on the date of service) BMI percentile documented as a value (i.e. 85th percentile) or BMI percentile on an age-growth chart meets criteria. Documentation must occur during the measurement year or the year prior to the measurement year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. BMI (date and value)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Weight (date and value)</td>
<td></td>
</tr>
<tr>
<td>2. Colorectal Cancer Screening¹,²</td>
<td>50 to 75 years</td>
<td>One of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Fecal occult blood test annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Flexible sigmoidoscopy every 5 years - OR -</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3. Colonoscopy every 10 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Digital rectal exam does not count toward compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Patients with a diagnosis of colorectal cancer or total colectomy are excluded</td>
<td></td>
</tr>
<tr>
<td>3. Breast Cancer Screening¹,²</td>
<td>50-74 years - women</td>
<td>At least one mammogram between October 1, 2012 to December 31, 2014</td>
<td>Women with bilateral mastectomy are excluded. Biopsy, ultrasound or MRI are not acceptable tests.</td>
</tr>
</tbody>
</table>
| 4. Controlling High Blood Pressure¹,²          | 18 to 85 years - women         | Patients with diagnosed hypertension. Of the denominator, members with a diagnosis of diabetes in the measurement year or year prior are flagged. Metrics are as follows: Age 18-59, BP <140/90 mm Hg  
Age 60-85 with diabetes, BP <140/90 mm Hg  
Age 60-85, no diabetes, BP <150/90 mm Hg  
MOST RECENT BP level in the measurement year is used. | Patient is considered hypertensive if they have at least one outpatient visit with a hypertension diagnosis in the first six months of the measurement year. |
| 5. Persistence of Beta Blocker Treatment¹      | 18+ years                      | Patients hospitalized with diagnosis of AMI who received persistent beta-blocker treatment for 6 months after discharge  | Adverse reaction to beta blocker therapy is reason for exclusion                      |
| 6. Comprehensive Diabetes                      | 18 to 75 years                 |                                                                           |                                                                                      |
| • HbA1c Screening¹                             | Annual HbA1c test              |                                                                           |                                                                                      |
| • HbA1c Level                                 | HbA1c <7% (select population)  |                                                                           | MOST RECENT level during the measurement year must be used.                          |
|                                              | HbA1c <8%                      |                                                                           |                                                                                      |
|                                              | HbA1c <9%¹,²                   |                                                                           |                                                                                      |
| • Retinal Eye Exam¹                            | Retinal or dilated eye exam by an eye care professional at least every two years. If patient has diagnosis of retinopathy, then annual retinal or dilated eye exam. | Eye exams results should be recorded in the medical record. Please request that all eye care providers send the PCP a copy of the results or a letter indicating the testing date, testing done and results. |
| • Monitor Nephropathy¹                         | 1. Annual nephropathy screening documented during the measurement year:  
• 24-hour urine for microalbumin |                                                                           | Documentation must occur during the measurement year. Evidence of nephropathy may include documentation of visit to a nephrologist, documentation of renal transplant, urine microalbumin test and documentation |

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¹ - Identifies measures included in NCQA accreditation scoring in 2015  
² - Identifies measures included in Medicare Star Ratings for 2015
<table>
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</table>
| - Blood Pressure Control | | • Timed urine for microalbumin  
| | | • Spot urine for microalbumin  
| | | • Urine for microalbumin/creatinine ratio  
| | | • 24-hour urine for total protein  
| | | • Random urine for protein/creatinine ratio  
| | | - OR -  
| | | 2. Evidence patient has nephropathy  
| | | - OR -  
| | | 3. Evidence of ACE/ARB therapy  
| | MOST RECENT blood pressure level in the measurement year. Blood pressure should be documented at least annually in the medical record:  
| | | • <140/90 mm Hg  
| | MOST RECENT level during the measurement year is used.  
| 7. COPD | 40+ years | Members with new diagnosis or newly active diagnosis of COPD who received spirometry to confirm the diagnosis  
| | | Members with COPD exacerbation with acute inpatient discharge or ED visit who were given (new Rx or evidence of active Rx):  
| | | • Systemic corticosteroid w/in 14 days  
| | | • Bronchodilator w/in 30 days  
| | | COPD exacerbation is defined as an acute inpatient discharge or ED encounter with a principal diagnosis of COPD  
| 8. Follow-up After Hospitalization for Mental Illness | 6+ years | Patients discharged after hospitalization for mental illness diagnosis that had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner.  
| | | Two rates are reported and described below:  
| | | • 7 Days  
| | | • 30 Days  
| | | Mental health diagnoses include:  
| | | • Other psychoses (295-299)  
| | | • Obsessive-compulsive disorder (300.3)  
| | | • Dysthyemic Disorder (300.4)  
| | | • Personality Disorders (301)  
| | | • Acute reaction to stress (308)  
| | | • Adjustment reacting (309)  
| | | • Depressive Disorder (311)  
| | | • Disturbance of Conduct, NEC (312)  
| | | • Disturbance of Emotions (313)  
| | | • Hyperkinetic Syndrome of Childhood (314)  
| | | Discharges followed by readmission or direct transfer to a nonacute facility are excluded.  
| | | Patients who received follow-up visit with a mental health provider within 7 days of discharge  
| | | Patients who received follow-up with a mental health provider within 30 days of discharge  
| 9. Antidepressant Medication Management | 18+ years | Patients diagnosed with an episode of major depression, are treated with antidepressant medications and who stayed on the medication treatment  
| | | Patients identified as above who remained on medication for at least 84 days  
| | | Patients identified as above who remained on medication for at least 84 days  

<p>| Quality Management |</p>
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</thead>
<tbody>
<tr>
<td>Effective Continuous Phase Treatment (^1)</td>
<td></td>
<td>Patients identified as above who remained on medication for at least 180 days</td>
<td>Patients with HIV diagnosis or members with a diagnosis of pregnancy during the measurement year may be excluded</td>
</tr>
<tr>
<td>10. Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (^2)</td>
<td>No age specification</td>
<td>Patients with a diagnosis of rheumatoid arthritis who received at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) in the measurement year.</td>
<td>Exclusions include members with bone mineral density test during 24 months prior to index episode start date (IESD), members with diagnosis of osteoporosis in the 12 months prior to IESD, members with Rx to treat osteoporosis.</td>
</tr>
<tr>
<td>11. Osteoporosis Management in Women Who Had a Fracture (^1, 2)</td>
<td>67 to 85 years</td>
<td>Women who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.</td>
<td></td>
</tr>
<tr>
<td>12. Monitoring for Patients on Persistent Medications</td>
<td>18+ years</td>
<td>Patients who receive a 180 day supply of ambulatory medication and at least 1 therapeutic monitoring event annually for the following:</td>
<td>Patients who have had an inpatient stay for any condition are excluded.</td>
</tr>
<tr>
<td>ACE or ARBs</td>
<td></td>
<td>• ACE/ARBs –</td>
<td></td>
</tr>
<tr>
<td>Diuretics</td>
<td></td>
<td>• Diuretics –</td>
<td></td>
</tr>
<tr>
<td>Digoxin</td>
<td></td>
<td>• Digoxin –</td>
<td></td>
</tr>
<tr>
<td>Combined (^1)</td>
<td></td>
<td>Combined rate (sum of 3 numerators divided by sum of 3 denominators)</td>
<td></td>
</tr>
<tr>
<td>13. Potentially Harmful Drug-Disease Interactions in the Elderly</td>
<td>65 years and older</td>
<td>Members with evidence of disease, condition or health concern who were given an ambulatory prescription for a contraindicated medication, with or after the diagnosis</td>
<td>Members with more than one condition may appear in the each measure for which they qualify.</td>
</tr>
<tr>
<td>History of falls and an Rx for anticonvulsants, nonbenzodiazepine hypotonic, SSRIs, antiemetics, antipsychotics, benzodiazepines or tricyclic antidepressants</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dementia and Rx for antiemetics, antipsychotics, benzodiazepines, tricyclic</td>
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<td></td>
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</tbody>
</table>
### MEASURE

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>INDICATORS</th>
<th>NOTES, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>antidepressants, H2 Receptor Antagonists, nonbenzodiazepine hypnotics or anticholinergic agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic renal failure and Rx for nonaspirin NSAIDs or Cox-2 Selective NSAIDs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total rate</strong></td>
<td></td>
<td>(Total rate is the sum of the 3 numerators divided by the sum of the 3 denominators)</td>
<td></td>
</tr>
</tbody>
</table>
| **Use of High Risk Medications in the Elderly** | 66 years and older | Members who receive at least one high risk medications or at least two different high risk medications. | High risk medications include:  
- Anticholinergic (excluding TCAs), first-generation antihistamines  
- Anticholinergic (excluding TCAs), anti-Parkinson agents  
- Antithrombotics  
- Cardiovascular, alpha agonists, central  
- Cardiovascular, other  
- Central nervous system, tertiary TCAs  
- Central nervous system, barbiturates  
- Central nervous system, vasodilators  
- Central nervous system, other  
- Endocrine system, estrogens with or without progestins; include only oral and topical patch products.  
- Endocrine system, sulfonylureas, long-duration  
- Gastrointestinal system, other  
- Pain medications, skeletal muscle relaxants  
- Pain medications, other |
| **Initiation of Alcohol and Other Drug Dependence Treatment** | No age specification | Patients with a new episode of alcohol or other drug dependence who receive treatment within 14 days of diagnosis through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization. | If the earliest diagnosis is found with an inpatient discharge, the inpatient stay is considered initiation treatment -- or -- if the earliest diagnosis is found with a detox, ED visit or outpatient visit, there must be a subsequent service within 14 days for compliance. |
| **Engagement of Alcohol and Other Drug Dependence Treatment** | No age specification | Patients who initiated treatment (as described above) and who had 2 or more additional services with an AOD diagnosis within 30 days of the initiation visit. | If treatment is initiated through an inpatient stay, the 30 days starts at the date of discharge. |

**Measures below are assessed through the annual CAHPS® satisfaction survey**

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Age Group</th>
<th>INDICATORS</th>
<th>NOTES, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flu Shots for Older Adults</strong></td>
<td>65+</td>
<td>Members who received an influenza vaccination between July 1 of the measurement year and the date when the Medicare CAHPS® survey was completed.</td>
<td>The Medicare CAHPS® survey is mailed to a sample of Medicare members each Spring.</td>
</tr>
<tr>
<td><strong>Pneumonia Vaccination Status for Older Adults</strong></td>
<td>65+</td>
<td>Medicare members who have ever received a pneumococcal vaccine.</td>
<td>The Medicare CAHPS® survey is mailed to a sample of Medicare members each Spring.</td>
</tr>
<tr>
<td>MEASURE</td>
<td>Age Group &amp; Sex (if indicated)</td>
<td>INDICATORS</td>
<td>NOTES, if applicable</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>19. Medical Assistance With Smoking Cessation (Advising Smokers to Quit)</td>
<td>18+</td>
<td>Members who are current smokers or tobacco users and who received smoking cessation advice during the measurement year.</td>
<td>The Medicare CAHPS® survey is mailed to a sample of Medicare members each Spring</td>
</tr>
</tbody>
</table>

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
**CMS Star Ratings**

The Medicare Advantage star rating system was created by the Centers for Medicare & Medicaid Services (CMS) to evaluate plans on management of chronic conditions, preventive care, access to care and member satisfaction. The ratings are obtained from HEDIS* scores, CAHPS** survey results, Health Outcome Survey results, claim data and member complaints and appeals. A 5 Star rating is the goal.

These ratings are posted on Medicare.gov for beneficiaries and potential members to review when determining which Medicare Advantage plan to select. Medicare Advantage plans that receive a 5 Star rating are allowed to enroll members throughout the calendar year. CMS also utilizes the Star Rating to determine the Quality Bonus Payment (QBP).

**Preventive Health**

Health Alliance places a strong emphasis on providing a highly developed preventive care services program for its beneficiaries.

One specific activity involves the implementation of preventive care guidelines to ensure beneficiaries are properly screened and educated regarding a wide range of conditions. With the input of multiple physician teams and a review of national recommendations, Health Alliance uses three resources for prevention: Institute for Clinical Improvement (ICSI), the United States Preventive Services Task Force (USPSTF) and the Center for Disease Control. To view the guidelines online, log in as a provider at YourHealthAlliance.org and click “Clinical Guidelines” under “Resources” in the footer.

These parameters are not inclusive of all proper methods of care. The ultimate judgment regarding the propriety of any preventive health care recommendation must be made by the physician in light of the individual circumstances presented by the patient.

Please feel free to convey your recommendations to the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112.

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* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
** CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Clinical Guidelines at a Glance
Health Alliance Clinical Guidelines are available on the provider/office manager portal of YourHealthAlliance.org. Under the “Resources” at the bottom of the page, select “Clinical Guidelines.” If you have questions or would like a paper copy of the guidelines, please call the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112. While clinical practice guidelines are useful aids in determining appropriate care practices for patients with specific clinical problems or prevention issues, the guidelines are not meant to replace the clinical judgment of the individual physician or establish a standard of care.

Clinical Guidelines are based on the best practice standards using national guidelines as seed guidelines. The content is reviewed annually, and updated to reflect any new updates and evidence.

Examples of Clinical Guidelines include:

- The Institute for Clinical Systems Improvement (ICSI), an independent, not-for-profit collaboration of health care organizations, works toward implementation of best clinical practices. Visit www.icsi.org, click “Guidelines & More,” then search by keyword, type/condition or alphabetically by name. Multiple guidelines are available. Those pertinent to current Health Alliance initiatives include:
  - ADHD: Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents — endorsed with qualifications from the American Academy of Pediatrics guideline, ADHD: Clinical Practice Guideline, and Supplement (behavioral health)
  - Diagnosis and Management of Asthma (respiratory disease)
  - Adult Depression in Primary Care (behavioral health)
  - Diagnosis and Treatment of Headache (other healthcare conditions)
  - Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD) (respiratory disease)
  - Osteoporosis, Diagnosis and Treatment (women’s health)
  - Obesity for Children and Adolescents, Prevention and Management of
  - Obesity for Adults, Prevention and Management of (preventive & health maintenance)
  - Tobacco Use – see Healthy Lifestyles, Preventive Services for Adults
- 2014 Standards of Medical Care in Diabetes
care.diabetesjournals.org, and click on “ADA Clinical Practice Recommendations”
www.nhlbi.nih.gov/guidelines/asthma/index.htm
- 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
circ.ahajournals.org/content/early/2013/11/11/cir.0000437738.63853.7a
- 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)
- Global Initiative for Chronic Obstructive Lung Disease (GOLD)
goldcopd.org, and click on “GOLD documents/2014 versions”
- NIAAA National Institute of Alcohol Abuse and Alcoholism “Helping Patients Who Drink Too Much”

Immunization Schedules
The Centers for Disease Control website provides immunization schedules and updates them throughout the year. Please visit cdc.gov/vaccines/ to find the most current immunization schedules for children, adolescents and adults.
PURPOSE OF THE POLICY

The purpose of this policy is to ensure clinical guidelines promoted by the plan are based on reasonable medical evidence, made available to appropriate practitioners, and reviewed/updated at least once every two years.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to adopt and disseminate practice guidelines for the provision of prevention, acute, chronic and behavioral health care services that are relevant to its enrolled membership. Practice guidelines are defined as "statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.” (source: Institute of Medicine).

PROCEDURES

1. Designated Quality Management Coordinator

1.1 Supports the guideline process by:
   • Facilitating guideline implementation, measurement and review/approval for their designated area and Disease Management Program
   • Maintaining the Health Alliance and Carle web sites.
     - Check web sites quarterly for appropriate links and updates.
     - Problems with the website links and updates shall be corrected by the Communications Coordinator responsible for the website.
   • Ensuring guidelines are consistent with Health Alliance UM criteria, member education materials and disease/case management programs.

1.2 Practitioners assess the National Guidelines Clearinghouse as the main resource available for new guidelines and updates, which includes but is not limited to, the Centers of Disease Control and Prevention (CDC), and American Congress of Obstetricians and Gynecologists (ACOG).
Quality Management

2. Approval

2.1 Guidelines are reviewed and approved at least once every two years. If not reviewed and approved at least every two years, then the guideline is void.

2.2 Guidelines are adopted for at least two medical conditions and at least two behavioral conditions. At least one behavioral guideline must address children and adolescents.

2.3 At least two of the guidelines provide the clinical basis for disease management programs for medical conditions.

2.4 The Quality and Medical Management Director or designee oversees review of the guidelines and makes these changes available to the Quality Improvement Committee.

2.5 Guidelines are sent to the Quality Improvement Committee (QIC) for review and approval annually.

2.6 QIC prioritizes guideline development, as needed, and is the Health Alliance approval body.

3. Distribution

3.1 After annual review of the guidelines, they are made available on the Health Alliance website.

3.2 Written notification of their availability is sent to all participating practitioners via an article in inforMED. The article includes instructions for obtaining a paper copy of the guidelines.

4. Measurement

4.1 The effectiveness of practice guidelines are “determined by scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert option, in the absence of professional standards” (source: NCQA).

4.2 Health Alliance measures performance against two important aspects of at least four clinical guidelines annually to determine practitioner adherence.

4.3 Two of the four guidelines must focus on behavioral health care.
Serious Reportable Events
Participating Provider shall notify Health Alliance within thirty (30) days of the occurrence of a Serious Reportable Event listed in Schedule C of the Participating Provider Agreement that affects a Health Alliance Member. Participating Provider shall also comply with the Health Alliance policy regarding Serious Reportable Events which is: issuance of a formal apology to the Member; reporting the event to Health Alliance; perform a root cause analysis of the event, including development of a corrective action plan that describes how the event occurred and corrective actions to prevent future occurrences which will not be shared pursuant the Illinois Medical Studies Act (735 ILCS 5/8-2001 et seq); and waive payment for costs associated with the occurrence of the event.

1. Surgery on the wrong body part
2. Surgery on the wrong patient
3. Wrong surgical procedure performed on a patient
4. Unintended retention of a foreign object in a patient after surgery
5. Intraoperative or immediately post-operative death in an ASA Class I patient (Death of a patient, who had been generally healthy, during or immediately after surgery for a localized problem)
6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
7. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility
9. Infant discharged to the wrong person
11. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
12. Patient death or serious disability associated with a medication error (wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
13. Patient death or serious disability associated with transfusion of blood or blood products of the wrong type
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
15. Patient death or serious disability associated with the onset of hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
16. Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates
17. Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
18. Patient death or serious disability due to spinal manipulative therapy
19. Patient death or serious disability associated with an electric shock while being cared for in a health care facility
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility
22. Patient death associated with a fall suffered while being cared for in a health care facility
23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider
25. Abduction of a patient
26. Sexual assault on a patient within or on the grounds of the health care facility
27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of the health care facility
28. Artificial insemination with the wrong donor sperm or donor egg

Adverse Events (includes Sentinel and Serious Reportable Events)
It is the policy of Health Alliance Medical Plans to have a formal procedure to provide structure and guidance regarding the review of adverse events for any potential injury that occurs while a member is receiving health care services from a participating practitioner/provider.

Sentinel Events
Sentinel Events are quality of care concerns or occurrences that can be submitted orally, in writing or identified through the concurrent review process. Health Alliance employs a Member Relations Quality Improvement Coordinator, a registered nurse that works closely with a medical director to provide a review of the concerns and take action, if needed.
Filing Procedures
A. All claims are processed at the Health Alliance office in Urbana, Illinois. The mailing address for submission of paper claims is:
   Health Alliance Medical Plans, Inc.
   Attn: Claims Department
   301 S. Vine St.
   Urbana, IL 61801-3347

B. Inquiries regarding claims payment should be directed to Health Alliance Customer Service Department in Urbana at 1-800-851-3379.

C. Claim requirements are as follows:
   - If you are filing a paper copy of your claim, the following services must be detailed on a HCFA 1500 or UB04 billing form. Minimum data requirements include:
     1. Provider Name, Address, and Telephone Number
     2. Type of Bill or Frequency Code Claim
     3. Federal Tax ID Number (employer identification number)
     4. Statement Covers Period (beginning and ending service dates of the period included on the bill)
     5. Patient Name, Member Number, Address, Birthdate and Sex
     6. Admission Date, Admission Hour, Type of Admission, Source of Admission
     7. Discharge Hour
     8. Patient Status
     9. Condition Codes, if applicable
    10. Occurrence Codes and Dates, if applicable
    11. Occurrence Span Code and Dates, if applicable
    12. Responsible Party Name and Address
    13. Value Codes and Amounts, if applicable
    14. Revenue Code
    15. Revenue Description
    16. HIPPS Codes and Modifiers/Rates
    17. CPT Codes and Modifiers
    18. Service Date required on outpatient series bills
    19. Units of Service
    20. Total Charges (by Revenue Code Category); includes covered and non-covered charges
    21. Non-Covered Charges, if known
    22. Payer Identification (primary/secondary)
    23. Release of Information Certification Indicator
    24. Prior Payment Information
    25. Insured’s Name, Health Alliance Member Number (11 digits), and Insured Group Name
    26. Principal, other, admitting/patient’s reason for visit, and E-code ICD-9-CM (or ICD-10 after October 2014) Diagnosis Codes (diagnosis codes must be coded to the highest degree of specificity)
    27. DRG Code
    28. Procedure Code(s)–ICD-9-CM and Date
    29. Attending Physician
    30. Other Physician
    31. Provider Representative Signature
    32. Date Bill Submitted
    33. Present on Admission Indicator
    34. Ambulance Pick-up and Drop-off Info, if applicable

D. Full charges are to be included on the claim form. Health Alliance will process claims according to member’s benefit plan and provider payment terms. Adjustments will be detailed on the paper Remittance Advice or electronic HIPAA 835.

E. Claims for members with other primary coverage should be filed to the primary carrier first. Remaining balances should be filed to Health Alliance with the claim form and primary payer’s Explanation of Benefits. Claims filed to Health Alliance without the primary payer’s Explanation of Benefits will be returned to the provider for resubmission. Secondary claims can also be submitted electronically with appropriate HIPAA 837 COB loops and segments populated.
F. Every member is issued a plastic, wallet-size identification card. As indicated, the face of the card includes the member’s preferred provider physician office visit, specialty visit and emergency room copayment or coinsurance.

G. The Provider’s Remittance Advice includes an explanation of payments, denials and adjustments for each detail charge, and is also included in this section.

H. Explanation of Benefits (EOB) are issued to members to show how their claims were processed. Members can opt out of receiving paper EOBs and request online EOB access by calling Health Alliance. A sample of Health Alliance’s EOB is included, as well as an explanation of the EOB.

I. Claim adjustments (i.e., for duplicate payments, overpayments, etc.) are deducted from the provider’s next claim payment. The Remittance Advice report will provide detail of all claims being paid and will also indicate any claims being adjusted.

J. Health Alliance utilizes a claims analysis software program called iCES. This system provides an extensive set of base rules that will utilize historical data to audit claims for appropriate coding guidelines.

iCES identifies coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The system does this by utilizing a knowledge base containing more than 9 million government and industry rules, regulations and policies governing health care claims. The editing rules are built upon nationally recognized and accepted sources, including American Medical Association CPT guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

**Per your Participating Provider Agreement with Health Alliance, you may not charge Health Alliance members for covered services except standard copayments, coinsurance and deductibles.**

K. Following are standard coding practices observed by Health Alliance:

Modifiers application: Health Alliance accepts all current CPT and HCPCS modifiers for physicians and facilities.

Most commonly used modifiers:
- 51 Multiple procedures by the same physician performed the same day. The highest level procedure is paid at 100 percent of fee schedule or contracted rate. All subsequent procedures are paid at 50 percent (this applies to facility charges as well). Exception: Multiple Scopes. Health Alliance follows the same guidelines as Medicare for payment of multiple scopes.
- 50 Bilateral procedures, this modifier is used when unilateral procedures are performed bilaterally. Payment will be 150 percent.
- 80 Assistant surgeon, Health Alliance reimburses for assistant per CMS guidelines indicating procedures where an assistant is necessary. Reimbursement is 25 percent.
- 62 Two surgeons, under certain circumstances the skills of two surgeons may be required. Both surgeons will report the indicated code with the –62 modifier. Reimbursement will be 62.5 percent to each surgeon.

Descriptive modifiers such as LT and RT will facilitate claims processing and often negate requests for additional documentation.

**Anesthesia Payment**

Health Alliance uses Medicare guidelines in regards to the base units. Anesthesia services are calculated in fifteen (15) minute time units. Time is rounded to the nearest fifteen (15) minute time unit. If less than five (5) minutes no time unit will apply; five (5) minutes to fourteen point nine (14.9) minutes, one time unit will apply. In addition our calculator takes the base, time, modifiers and qualifying circumstances into consideration when calculating payments.

In addition to the time units calculation noted above, the National Coverage Provisions for Anesthesia Services established unique modifiers for anesthesia services that tell the payer if the services performed were medically supervised by a physician or performed without medical direction by or assistance from a physician. Those modifiers indicating services were provided by both anesthesiologist and Certified Registered Nurse Anesthetist (CRNA) will be entered in the modifier schedule at a 50 percent reduction (similar to modifier 51). The system will take the appropriate reductions at the time of service.
Claims Submission

The four modifiers that are updated to 50 percent are:

- **AD** – Medically supervised by a physician for more than four concurrent procedures
- **OK** – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- **QX** – CRNA with medical direction by a physician
- **QY** – Medical direction by one CRNA or by an anesthesiologist

**Multiple Scope Billing**

We follow the same guidelines as Medicare for multiple scope billing reimbursement. This applies different logic than a multiple procedure reduction with the 51 modifier.

Health Alliance refers to endoscopic Base code and Secondary codes when determining the correct allowable for multiple scopes performed during same session.

Medicare has created a list of the base codes used for paying secondary endoscopic procedures related to the primary scope.

The Base code has assigned secondary codes (family of codes).

When billing, each procedure would be reported. But because the value of the base code is included in each code in that particular “family of codes”, a different reduction logic is applied. All of this is outlined in Medicare guidelines.

If two unrelated endoscopic procedures are performed in the same session, but not within the same family of codes, then modifier 51 multiple procedure logic would apply. This is when the highest level procedure is paid at 100% of fee schedule or contracted rate, and all subsequent procedures as paid at 50%.

Some websites which may be helpful:

- [www.cms.hhs.gov/feeschedulegeninfo/](http://www.cms.hhs.gov/feeschedulegeninfo/) – physician fee schedule; PFS relative value files

Reimbursement for supplies billed in addition to a surgical procedure are considered to be inherent in the procedure.

*When reporting supplies, the appropriate HCPCS code must be indicated. Unlisted procedures/services; as industry standards, Health Alliance requires documentation for clarification.

**Annual Coding Changes**

**ICD-10 CM:** effective October 1 of this year, Health Alliance begins accepting new ICD-10 diagnosis and procedure codes.

**CPT-HCPCS:** effective January 1 of each year Health Alliance will begin accepting new/revised procedure codes. To be compliant with HIPAA standards, there is no longer a 90-day grace period for discontinued codes. Resubmission of a new/more appropriate code will be required.

Global surgery billing includes all necessary services normally furnished by the surgeon beginning with the day before surgery, the day of surgery, and the designated post-op period. Health Alliance follows the same guidelines as CMS. To indicate a service is not part of the global package, appropriate modifiers must be used (i.e., –24, –25, –57, –78, –79.)

Global obstetrical billing normally requires one global copayment to cover all physician visits for routine prenatal care and post-partum check-up. Specialty visits during pregnancy, and services provided by a perinatologist outside the scope of routine prenatal care, do have an additional office copayment.
Health Alliance Specific Reimbursement Policy

Venipunctures: Health Alliance considers the collection of venous blood to be incidental to performing the laboratory test. However, Health Alliance will reimburse for the venipuncture if the laboratory test is not performed in-house but sent to a reference lab. In that event, the laboratory test code(s) must be appended with the 90 modifier.

Timely Payment

The Medicare health plan must pay 95 percent of clean claims from non-contract providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.

Note: Reimbursement appeals should be sent to the Health Alliance Claims Department.

Electronic Filing

Speed, accuracy and ease of processing are just a few of the reasons filing electronic claims is so popular. Health Alliance accepts both physician and hospital claims electronically. Medical offices and hospitals that use electronic filing also save money. All our multi-specialty groups and facilities are taking advantage of this technology. Isn’t it time you did the same?

Electronic filing eliminates double data entry – your staff are the only ones who enter claim information. Once the claim reaches Health Alliance, it is automatically loaded in our system, eliminating days of hand processing, sorting and scanning. Ensure the most accurate, rapid claims filing turn around times by using an electronic filing system to file your Health Alliance claims. Please contact your billing system vendor and request they file your claims through RelayHealth under payer ID 77950 to make sure claims reach Health Alliance. You can also call RelayHealth directly at 1-877-411-7271 to discuss options for submitting your claims electronically to Health Alliance. A no-cost option is also available with MD On-line at 1-888-499-5465 or MDON-LINE.com.

Health Alliance requires your ten-digit National Provider Identifier (NPI) for electronic claims.

All electronic claims must comply with the HIPAA 5010 transaction set as required by the Centers for Medicare and Medicaid Services (CMS).

If you have questions, please have your office staff call the Health Alliance System Configuration Department at 1-800-851-3379, extension 8566.
Claims Submission

Electronic Claim Critical Error Message
Please note that if a claim has a critical error, it is not stored in our system. You have 90 days to resubmit a claim.
The following is a summary of the most common critical errors you may receive when attempting to submit claims electronically:

Admitting Provider not on file or not submitted.
• This error message is limited to inpatient claims because admitting provider is a required field. Often times these errors can be fixed internally after admitting provider record has been reviewed to determine UPIN and/or license number. However, if the information is unable to be verified, the claim will reject and have to be submitted on paper.

DRG Code not submitted or is invalid.
• The submission of the DRG is required even if the provider is not reimbursed by DRG. This error message is limited to inpatient claims because the DRG is a required field. This error indicates the DRG field was either blank or invalid (i.e., miss key, old code).

Provider not on file.
• Health Alliance requires your NPI for electronic claims. If this number is not submitted or doesn’t find a valid match in our system, you will receive this error message. Please note, it is extremely important that your NPI is submitted in its entirety and is accurate, because an invalid submission may result in a match on another provider’s identification number. In addition, every provider location with a unique provider number must be submitted under their respective identification number.

Vendor not on file.
• This error message indicates the vendor number (tax ID) submitted does not match our system.

Group and/or member is not eligible.

Member not eligible—coverage group contract date error.
• This error message indicates the group coverage record or the member record is no longer effective.

Contract history record not found.
• This error message occurs when a provider has multiple records and the system is trying to read a record that has been terminated or marked as DO NOT USE. These errors can often be corrected internally so that resubmission is not required by removing the NPI and the tax ID from the header of the terminated records.

G/L distribution code DEF not found.
• This error message is completely an internal system issue at Health Alliance. These claims should be submitted in paper format for manual processing.

Modifier not on file.
• The two-digit modifier submitted on the claim is either miss keyed or invalid. The correct modifier must be submitted for the claim to load into the production system.

Price Category Record not found.
• This often means procedure code is not found in the fee schedule for pricing and claim must be resubmitted.

Express Line—Your Quick Link to Information
We have priorities at Health Alliance—and superb customer service is at the top of the list. To enhance our ability to serve both members and providers better, Health Alliance offers Express Line. Using a touch-tone phone, you can call this virtually “round-the-clock” system to check patient eligibility. Express Line is not replacing the Customer Service Department. Callers will always have the option of speaking directly with a Customer Service representative.

Simply dial 1-800-851-3379 to be connected to the system. Express Line is available 24 hours on the weekend and all day Monday-Friday except from 10 p.m. to 2 a.m. This secure and easy-to-use system can be accessed using your provider number. If you call regarding a patient, you will need the patient’s member number and date of birth. Members also will be able to request an ID card and check eligibility.

Electronic Funds Transfer
Health Alliance offers electronic funds transfer (EFT) through Emdeon. EFT can reduce postal delays and may reduce administrative steps associated with issuing or depositing payments. To enroll, you can either download the enrollment form from the Emdeon website at www.emdeon.com/epayment/ProviderSolutions/Breakthrough/provider_enroll_now.php or call Emdeon at 1-866-506-2830 and select Option 1. By enrolling in Emdeon’s EFT program, providers are signing up to receive electronic payment distribution for all payers participating in Emdeon’s EFT program. No additional EFT agreements are required with the participating payers.

Emdeon’s EFT program is HIPAA compliant and confidential. Once enrolled, it usually takes 2-3 weeks for payments to begin. If you have questions about enrolling, please contact Emdeon at 1-866-506-2830 and select Option 2.
Claims Submission

Remittance Advice

Health Alliance
Attn: Cash Services
301 South Vine Street
Urbana, IL 61801

Electronic Service Requested

Pay $6,769.47

PAYMENT TRANSFERRED ELECTRONICALLY

Busey Bank

EFT NO:

**VOID**

NON-NEGOTIABLE

NON-NEGOTIABLE

VOID AFTER 180 DAYS
### Remittance Advice

**EFT #:**
**EFT Date:**
**EFT Amount:** 6,769.47
**Tax ID:**
**Provider ID:**
**National Provider**

---

#### PAYMENT TRANSFERRED ELECTRONICALLY

<table>
<thead>
<tr>
<th>Claim #:</th>
<th>Provider:</th>
<th>Claim Comment:</th>
<th>Patient Name:</th>
<th>Plan: HEALTH ALLIANCE FI</th>
<th>Patient Id:</th>
<th>Account #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ROUTINE ASSISTANCE OF AN ANESTHESIOLOGIST/CRNA FOR UPPER/LOWER GI ENDOSCOPIC PROCEDURES IS NOT MEDICALLY NECESSARY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/CO-PAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>00740 F2 QZ QS</td>
<td>707.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
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</table>

NO PCP REFERRAL/NO PRIOR AUTHORIZATION OBTAINED

| CLAIM TOTALS: | 707.00 0.00 0.00 0.00 0.00 0.00 |

<table>
<thead>
<tr>
<th>Claim #:</th>
<th>Provider:</th>
<th>Claim Comment:</th>
<th>Patient Name:</th>
<th>Plan: HEALTH ALLIANCE FI</th>
<th>Patient Id:</th>
<th>Account #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/CO-PAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>00142 AA QS</td>
<td>505.00</td>
<td>111.15</td>
<td>0.00</td>
<td>393.85</td>
<td>CO45</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>111.15</td>
</tr>
</tbody>
</table>

PROVIDER CONTRACT APPLIED

| CLAIM TOTALS: | 505.00 111.15 0.00 393.85 0.00 0.00 |

<table>
<thead>
<tr>
<th>Claim #:</th>
<th>Provider:</th>
<th>Claim Comment:</th>
<th>Patient Name:</th>
<th>Plan: HEALTH ALLIANCE FI</th>
<th>Patient Id:</th>
<th>Account #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/CO-PAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>01961 F2 QZ:</td>
<td>1,919.00</td>
<td>984.16</td>
<td>984.16</td>
<td>934.84</td>
<td>CO45</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

PROVIDER CONTRACT APPLIED

| CLAIM TOTALS: | 1,919.00 984.16 984.16 934.84 0.00 0.00 |

---

97
### Claims Submission

<table>
<thead>
<tr>
<th>Claim #</th>
<th>Provider</th>
<th>Claim Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Claim 1:
- **Patient Name:** HEALTH ALLIANCE FI
- **Plan:** HEALTH ALLIANCE FI
- **Patient Id:** Account #:

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Total Billed</th>
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<th>Deduct/Copay</th>
<th>Adjust</th>
<th>Adj Code</th>
<th>Not Covered</th>
<th>NCV RSN</th>
<th>Withhold</th>
<th>Paid</th>
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</thead>
<tbody>
<tr>
<td>CLAIM TOTALS:</td>
<td>2,020.00</td>
<td>1,045.67</td>
<td>1,045.67</td>
<td>974.33</td>
<td>CO45</td>
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<td>0.00</td>
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</tbody>
</table>

**ANESTH, SPINE, CORD SURGERY**

#### Claim 2:
- **Patient Name:** HEALTH ALLIANCE FI
- **Plan:** HEALTH ALLIANCE FI
- **Patient Id:** Account #:

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Total Billed</th>
<th>Allowed</th>
<th>Deduct/Copay</th>
<th>Adjust</th>
<th>Adj Code</th>
<th>Not Covered</th>
<th>NCV RSN</th>
<th>Withhold</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>00170 32 1/2 QZ</td>
<td>784.00</td>
<td>0.00</td>
<td>0.00</td>
<td>784.00</td>
<td>OA18</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**ANESTH, PROCEDURE ON MOUTH**

**DUPLICATE CLAIM/SUBMISSION**

#### Claim 3:
- **Patient Name:** HEALTH ALLIANCE FI
- **Plan:** HEALTH ALLIANCE FI
- **Patient Id:** Account #:

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Total Billed</th>
<th>Allowed</th>
<th>Deduct/Copay</th>
<th>Adjust</th>
<th>Adj Code</th>
<th>Not Covered</th>
<th>NCV RSN</th>
<th>Withhold</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>00142 AA 1/2 QZ</td>
<td>606.00</td>
<td>111.15</td>
<td>0.00</td>
<td>494.85</td>
<td>CO45</td>
<td>0.00</td>
<td>0.00</td>
<td>111.15</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**ANESTH, LENS SURGERY**

**PROVIDER CONTRACT APPLIED**

#### Claim 4:
- **Patient Name:** HEALTH ALLIANCE FI
- **Plan:** HEALTH ALLIANCE FI
- **Patient Id:** Account #:

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Total Billed</th>
<th>Allowed</th>
<th>Deduct/Copay</th>
<th>Adjust</th>
<th>Adj Code</th>
<th>Not Covered</th>
<th>NCV RSN</th>
<th>Withhold</th>
<th>Paid</th>
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</thead>
<tbody>
<tr>
<td>PAYER TOTALS</td>
<td>36,506.60</td>
<td>12,536.00</td>
<td>4,536.73</td>
<td>24,932.80</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>6,769.47</td>
</tr>
</tbody>
</table>

Any appeal of a recoupment must be made within 60 days after receipt of this remittance advice. Note: Reimbursement appeals from contracted providers should be sent to the Health Alliance Contracting and Provider Services Department, 301 S. Vine St., Urbana, IL 61801. Reimbursement appeals from non-contracted providers should be sent to the Health Alliance Claims Department at: Health Alliance Claims Department, 301 S. Vine St., Urbana, IL 61801.

**Code:** Description:
- CO45: Charges exceed your contracted/legislated fee arrangement.
- OA18: Duplicate claim/service.
- OA23: Payment adjusted because charges have been paid by another payer.
Remittance Form Description

Section 1—Vendor Information Block
Includes Vendor (same as Federal Tax ID #), Vendor Name, amount of check and check number.

Section 2—Title Line for Claim Data
This line describes each data element printed per claim detail. The corresponding data for this line is found under the Patient Identification Line.

Section 3—Patient Identification Line
The claim data is sorted in alphabetical order by Patient Name. This line provides the patient’s name (last name, first name and middle initial) and the patient’s Health Alliance member number. Following the patient line is the detailed claim information.

Section 4—Claim Data Lines
This section provides claim data under the title lines described in each patient identification line. Claim data is entered in detail; therefore, multiple lines per invoice will be shown.

A. Provider Name
B. Provider Account #
C. Admission Data/1st Date of Service on Invoice
D. Form #
   • Health Alliance assigned claim
E. Proc Code
   • Each Revenue Code, CPT4 Code, or HCPCS Code on the Invoice will be listed in this column.
F. Description
   • A description of each Procedure Code will appear here.
G. Billed $
   • The charge corresponding to each procedure code
H. Allowed $
   • The Allowed $ for each detail line. Provider discounts, charges over usual and customary, etc. are deducted from Billed $ to arrive at Allowed $.
I. Adjust $
   • This is the difference between Billed $ and Allowed $.
J. Adj. Rsn
   • Adjustment Reason codes appear to define the difference between Billed $ and Allowed $. A legend of the codes prints with each remittance.
K. Not Cov $
   • This amount field includes charges and payments made by other carriers (Medicare, commercial, etc.)
L. Not Covered Rsn
   • This code defines the reason why dollars are in the not covered column. A legend of the codes prints with each remittance.
M. Copay + Deduct
   • This amount field includes copayments, coinsurance and deductibles.
N. Withheld $
   • This field contains $ withheld as part of the provider payment terms.
O. Paid $
   • This is the amount paid for this line.

The remittance report provides totals for each claim/invoices and provides grand totals at the end of the report for balancing with the check.
Health Alliance
Attn: Eligibility
301 South Vine Street
Urbana, IL 61801
Electronic Service Requested

EXPLANATION OF BENEFITS
THIS IS NOT A BILL
RETAIN COPY FOR YOUR RECORDS

Date:
Claim #:
Member #:
Group: MEDICARE ADVANTAGE
Processed Date:
Check to be Issued To:
Provider

PLEASE SEE LAST PAGE FOR IMPORTANT INFORMATION

PROVIDER:

<table>
<thead>
<tr>
<th>Date of Service / Description</th>
<th>Total Charges</th>
<th>Provider Discount / Adjust</th>
<th>Deductible</th>
<th>Copay / Coins</th>
<th>Non-Covered Charges</th>
<th>Other Insurance Paid</th>
<th>Paid by Health Alliance</th>
<th>Non-Covered Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>R300 - LABORATORY OR (LAB)</td>
<td>170.00</td>
<td>138.55</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>31.45</td>
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<td>R300 - LABORATORY OR (LAB)</td>
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<tr>
<td>R300 - LABORATORY OR (LAB)</td>
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<tr>
<td>R301 - LAB/CHEMISTRY</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>23.13</td>
<td></td>
</tr>
</tbody>
</table>
# Explanation of Benefits Description

**Date of Service:** Date the patient received services.

**Service Code/Description:** Service code and description of services received.

**Total Charges:** Provider’s charge for services received.

**Provider Discount or Adjustment:** Contractual discount or amount provider must write off.

**Deductible:** The portion of the charges applied to your plan deductible.

**Copay/Coinsurance:** The portion of charges you are responsible for as copayments or coinsurance as defined by your plan.

**Non-Covered Charges:** Charges not covered by your plan.

**Other Insurance Paid:** The amount paid by another insurance carrier or Medicare.

**Amount Payable by Health Alliance:** The amount Health Alliance will pay for services received.

**Non-Covered Reason:** Refer to the reason code(s) printed at the end of this Explanation of Benefits.
PURPOSE OF THE POLICY

This Policy ensures that all Medicare Advantage claims are determined to be clean or non-clean, in accordance with CMS’s definition, on a consistent basis for the purpose of processing each claim for payment in compliance with CMS requirements, as well as for all reporting purposes.

STATEMENT OF THE POLICY

Health Alliance will follow CMS guidelines as it relates to the determination of whether a claim is non-clean. In addition, staff will accurately document the date the claim became clean, as well as the action taken to secure additional information.

PROCEDURES

1. Claims

1.1 A claim can be marked as non-clean if it meets one of the following conditions:

- Invalid or missing procedure and/or diagnosis codes;
- Missing the provider of service
- Missing or invalid dates of service
- Requires medical documentation
- Requires referring physician or prior authorization
- Lacks patient information (name and member number, both, are missing)
- Invalid or missing place of service
- Invalid or missing bill type on UB
- Member’s eligibility has not been confirmed by CMS
- Missing or invalid accident flag
- Missing diagnosis pointers
- Missing DRG, RUG, HIPP, or any other code required for pricing claim like Medicare.

Note: The need for Medical Management review does not make a claim non-clean.

1.2 Enter the date the claim became clean (based on claim note documentation) into the Clean Date field if claim is non-clean; no action needed if claim is clean.
2. Medical Management Coordinator

2.1 Enters a claim note indicating that medical records were needed to determine coverage and ordered on xx/xx/xx date (claim note must include date records were ordered). Must also document in the claim note the date the medical records were received. This is the date the claim became clean.

3. Claims Analyst or Senior Claims Analyst

3.1 Upon release of pended claim from medical management department, checks claim notes to see if additional documentation was needed to determine coverage. If records were ordered by medical management department to determine coverage, enters the date the medical records were received in Clean Date field.

3.2 If the need for a reversal or amendment to original entry is due to late charges, adding detail lines, etc., the new received date or request date should be entered into the “Clean Date” field. A claim note should also document this action.

3.3 If the original payment was entered to the wrong vendor or vendor address, the original claim reversal and the new claim entry shall contain a “Clean Date” equal to the date we were advised of the error.

4. Operations Auditor

4.1 Selects either clean or all claims as needed for reporting purposes when running turnaround time reports.

4.2 Determines whether claims have been correctly coded as clean or non-clean when auditing Medicare Advantage claims. Also, if a claim has been coded as non-clean, checks to make sure that a claim note has been entered in the system and/or documentation is attached to the claim.
PURPOSE OF THE POLICY

To document specific guidelines for the full or partial denial of Medicare Advantage claims.

STATEMENT OF THE POLICY

Health Alliance will follow Medicare/CMS’s guidelines when denying a Medicare Advantage claim.

PROCEDURES

1. Procedures or Services Not Covered by Medicare

1.1 Procedures or services not covered by Medicare can be non-covered by Medicare Advantage unless coverage is included in the member’s Evidence of Coverage.

1.2 A description of “generic” non-covered procedures or services will be documented as a claim note, when the specific description of the item or service is provided on the claim.

   • Example: Procedure A9270 – Not Covered Services. This procedure can be denied without additional information from the provider or member, but if a description of the procedure or service is provided, it will be documented in the claim note.

2. Denied Authorizations

2.1 When Medical Management denies an authorization, they will include specific instruction in the Auth comment field as to whether the claim is to be denied as provider responsibility or member responsibility.

2.2 Provider responsibility – if an authorization was entered and denied to denote that the provider failed to pre-certify, the comments should note the provider is responsible. Adjust the claim to allow $0 with an adjustment reason of an ‘8’ – “No referral or pre-certification obtained.” The charges will appear on the Member’s EOB and the provider remittance advice as provider responsibility.

2.3 Member responsibility: If an authorization is denied for medical necessity, cosmetic or personal convenience, the auth comment will indicate Member responsibility. Update the claim to make the allowed amount and not covered amount equal to the billed amount. Use an appropriate not covered reason code (see Section 7 below).
3. **Affiliated Provider Claims**

3.1 Denial of affiliated provider claims must be scrutinized very closely. Medicare Advantage members cannot be held responsible for:

- Specialty provider claims (even if they were not referred by their primary care physician)*
- Claims requiring pre-certification. This is the provider responsibility.

*Unless the service provided is specifically excluded in the member’s Evidence of Coverage (EOC), i.e., cosmetic surgery.

4. **Unaffiliated Provider Claims**

4.1 The claims staff has the authority to deny non-emergent unaffiliated provider claims for lack of referral, without pending to Medical Management.

4.2 Claims billed by unaffiliated providers for ancillary services (i.e., laboratory, radiology) that have been ordered by an affiliated provider are not to be denied.

5. **Emergently Needed Services**

5.1 Emergent services are not reviewed for medical necessity and are not subject to denial, whether provided in a hospital or urgent care setting.

6. **Durable Medical Equipment**

6.1 Durable Medical Equipment (DME) providers are not to bill the health plan for equipment once it has been picked up from the member’s home. Should this occur, the claim should be adjusted to a $0 amount with an adjudication reason of ‘G’ – inappropriate coding or billing. The charge will appear on the Member’s EOB and the provider remittance advice as provider responsibility.
# Claims Submission

### 7. Not Covered Reason Codes (Member Responsibility)

7.1 Only the not covered reason codes below should be used for Medicare Advantage claim denials to the member.

<table>
<thead>
<tr>
<th>Affiliated Provider Claims</th>
<th>Non-Affiliated Provider Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Exceeds limits governed by Policy</td>
<td>01 Exceeds limits governed by Policy</td>
</tr>
<tr>
<td>02 Personal convenience items are not covered by the Plan</td>
<td>02 Personal convenience items are not covered by the Plan</td>
</tr>
<tr>
<td>03 Private room is limited to semi-private rate</td>
<td>03 Private room is limited to semi-private rate</td>
</tr>
<tr>
<td>07 Disposable items are not a covered benefit</td>
<td>07 Disposable items are not a covered benefit</td>
</tr>
<tr>
<td>08 Dentistry is not a covered benefit</td>
<td>08 Dentistry is not a covered benefit</td>
</tr>
<tr>
<td>09 Contact lens evaluations are not covered</td>
<td>09 Contact lens evaluations are not covered</td>
</tr>
<tr>
<td>14 Prescription drugs are not covered by the Plan</td>
<td>14 Prescription drugs are not covered by the Plan</td>
</tr>
<tr>
<td>20 No response for additional information requested</td>
<td>20 No response for additional information requested</td>
</tr>
<tr>
<td>21 Eye and ear supplies are not covered by the Plan</td>
<td>21 Eye and ear supplies are not covered by the Plan</td>
</tr>
<tr>
<td>26 Services for cosmetic purposes are excluded</td>
<td>26 Services for cosmetic purposes are excluded</td>
</tr>
<tr>
<td>27 Ambulance coverage limited to emergency conditions</td>
<td>27 Ambulance coverage limited to emergency conditions</td>
</tr>
<tr>
<td>28 Charges are related to a work injury</td>
<td>28 Charges are related to a work injury</td>
</tr>
<tr>
<td>30 Services provided are not covered by the Plan</td>
<td>29 Services obtained at a non-affiliated provider</td>
</tr>
<tr>
<td>31 Employment physicals are not covered by the Plan</td>
<td>30 Services provided are not covered by the Plan</td>
</tr>
<tr>
<td>TF Submission date exceeds time limitation</td>
<td>TF Submission date exceeds time limitation</td>
</tr>
</tbody>
</table>

### 8. Auditing

8.1 Inappropriate denials need to be identified and corrected immediately.

8.2 The Audit Department performs a review of a statistically valid sample of member denied claims on a monthly basis.

8.3 The Audit Department will validate the appropriateness of claim denials as part of their standard audit procedure.
PURPOSE OF THE POLICY

To document the procedures for determining the reimbursement allowables for out-of-network clinical lab claims paid at Medicare rates.

STATEMENT OF THE POLICY

Health Alliance will follow CMS guidelines to ensure proper payment for out-of-network clinical lab charges based on Medicare allowables.

PROCEDURES

1. Obtaining the Medicare Clinical Lab allowed amount for services provided in the State of Illinois.

1.1 The P5 fee schedule in the AS400 includes the Medicare Clinical Lab allowables for Illinois.
1.2 From the System Selector, enter UT for Utilization,
1.3 Type DSPPCPF for Display Price Category Procedure File and press enter.
1.4 Select F7-Price Category.
1.5 Type P5 for the price category and press enter.
1.6 Type the procedure code of the lab service, press enter.
1.7 The allowable for the procedure code will be reflected as the price.
1.8 If the claim date of service is on or after the effective date, use the current price. Otherwise, use the appropriate price determined by date of service.

2. Obtaining the Medicare Clinical Lab allowed amount for all other states.

2.1 Clinical lab is priced according to the state the services were provided.
2.2 Carrier and locality codes are not required to price clinical lab.
2.3 The website to obtain the clinical lab allowables for each state is www.cms.hhs.gov.
   • Select Medicare.
   • Select Clinical Laboratory Fee Schedule from the Medicare Fee-for Service Payment section.
   • Select Fee Schedule from the list of options under Clinical Laboratory Fee Schedule page.
2.4 To download this file, click on the year needed. This is a .zip file. You will be asked to “accept” the agreement to use this file.
2.5 Click on the appropriate file you want to download.
2.6 Click on “open” to download the file.
2.7 The file is ready to transfer to your desktop.
2.8 Click and drag the Excel spreadsheet named clabyear.csv (year of claim) file to your desktop.
2.9  You will only have to download this file once per each plan year.
2.10 To obtain the allowable for a lab code, click EDIT and then Find.
2.11 Enter HCPC code and choose the state to obtain the allowable.

3. Applying the allowed amount for the Claim Detail

3.1 Enter the allowed amount on the claim detail.
3.2 Enter an ‘A’ adjustment reason code on the claim detail to identify that the amount was adjusted because the Medicare allowable was applied.
PURPOSE OF THE POLICY

To document the procedures for determining the reimbursement allowables for Medicare Advantage out-of-network physician claims.

STATEMENT OF THE POLICY

Health Alliance will follow CMS guidelines to ensure proper payment of out-of-network physician claims based on Medicare allowables.

PROCEDURES

1. Accessing Physician Fee Schedules

1.1 Access CMS.gov website
1.2 Click Tab: Start Search
1.3 Accept License for Use

2. Medicare Physician Fee Schedule Search Criteria

2.1 Select the year of the Medicare Physician Fee Schedule that you want to see.
2.2 **Type of Information** - Select one of the five types of information that you want to search:
   - Pricing Information – provides pricing amounts and all of the components (RVU’s, GPCI’s, payment policy indicators, etc.) used to calculate the prices.
   - Payment Policy Indicators – provides only payment policy indicators information.
   - Relative Value Units – provides only Relative Value Units information.
   - Geographic Practice Cost Index – provides only Geographical Practice Cost Index information.
   - All – provides information for each of the above types of information.
2.3 **HCPCS Option** - Select one of the three HCPCS options (Skip this step if the Geographic Practice Cost Index option is selected):
   - Single HCPCS Code – allows you to search for information for one procedure code.
   - List of HCPCS Codes – allows you to search for information for up to 5 procedure codes; you will need at least two procedure codes to use this option.
   - Range of HCPCS Codes – allows you to search for information for a range of procedure codes; you need to enter starting and ending procedure codes for your range.
   · Note: It is recommended that you use a small range since the response time will be longer for a larger range.
2.4 **Carrier Options** - Select one of the four Carrier options based on the ‘Type of Information’ option selected in Section 2.2 (Skip if ‘Payment Policy Indicators’ or ‘Relative Value Units’ option was selected):

- **National Payment Amount** – allows you to search for information for only the national payment amount. The national payment amount is designated with a carrier locality code of “0000000”.
- **Specific Carrier** – allows you to search for information for a specific Part B carrier.
- **Specific Locality** – allows you to search for information for a specific Part B carrier locality.
- **All** – allows you to search for information for the entire nation (results will include the national payment amount as well as all carrier localities).

2.5 **HCPCS Code** - Enter the HCPCS Code based on the HCPCS Option selected in Section 2.3, (skip if ‘Geographic Practice Cost Index’ option was selected):

- **Single HCPCS Code**
  - Enter the HCPCS code that you want to search the information for.
  - Select a Modifier Value
- **List of HCPCS Codes**
  - Enter a list of HCPCS codes; you can enter 2, 3, 4, or 5 codes.
  - Select a Modifier Value
- **Range of HCPCS Codes**
  - Enter a range of HCPCS codes; you must enter the starting and ending HCPCS codes
  - Select a Modifier Value

3. **Submit Search Criteria**

3.1 Review and submit search criteria based on the Carrier Options selected in Section 2.4 (Skip if ‘Payment Policy Indicators’ or ‘Relative Value Units’ option was selected):

- **National Payment Amount**
  - Click on ‘Submit’
- **Specific Carrier**
  - Select a carrier
  - Click on ‘Submit’
- **Specific Locality**
  - Select a carrier locality
  - Click on ‘Submit’
- **All**
  - Click on ‘Submit’

4. **Applying the Allowed Amount to the Claim Detail**

4.1 Write the allowable amount on the claim and enter the claim on the AS400 system.
PURPOSE OF THE POLICY

The purpose of this policy is to document the process for applying OPPS payment methodology to certain claims for payment.

STATEMENT OF THE POLICY

Health Alliance utilizes the OPPS payment methodology for certain products and providers. This outpatient pricing is obtained via an off-line software program called Webstrat, which is owned by Optum Insight.

As of 8/17/05 this pricing methodology applies to:
- Contracted Medicare Advantage PPO providers
- Non-contracted Medicare Advantage PPO providers
- Non-contracted Medicare Advantage HMO providers
- Some non-contracted Health Alliance commercial providers

As of 1/01/08 this pricing methodology also applies to:
- Some contracted Med Advantage HMO providers
- Some contracted Health Alliance commercial providers

PROCEDURES

1. Initial Receipt of Reimbursement Details

1.1 System Configuration receives contract and reimbursement details from Contracting and Provider Services.
   - Adds provider note indicating % of Medicare APCs provider is being reimbursed.
   - If provider reimbursed 100% of Medicare, the pricing rule will be WB9. If reimbursed something other than 100%, the pricing rule will be WBS.
Claims Submission

2. Claims-Automated Pricing

2.1 Claim header screen shows Webstrat status to determine if AS400 claim went to Webstrat for pricing
   • C: Configuration Error
     · Requires review and follow up with System Configuration
   • E: Excluded due to bill type
     · Bill type is not a bill type priced through APC pricing
   • M: Manually priced
     · Webstrat price manually applied in MC400 by analyst
   • P: Priced by Webstrat Automation
     · Webstrat price systematically applied in MC400 through automation
   • S: Submitted
     · Claim was submitted to Webstrat; pricing not yet returned to claim.
   • X: Split Claim
     · Claim was submitted to Webstrat and is a split claim

2.2 To review claims in Webstrat, key in medical record number which is a combination of the primary date of service and the MC400 form number
   • i.e., 1210201289210569 (DOS: 12/10/12, Form# 89210569)

2.3 Click Search
2.4 Click on record to pull claim up in Webstrat
2.5 Edits generated by Webstrat are keyed into the MC400 claim notes and appropriate details are adjusted with an ‘I’ adjustment reason code for inappropriate billing when no pricing available by line or entire claim.

3. Claims-Paper Claims/Manual Entry

3.1 Receives claim that needs to be priced by APCs. Claim will bring in no allowed amount and will be attached to the OPPS fee schedule.

3.2 Claims Analyst keys the following fields from the paper claims or MC400 claim into the Webstrat Demographics Screen.
   • Provider’s NPI Number and Tax
   • Select Payor ID from drop down box
   • MedRec# = Date of Service + MC400 Form # keyed together
   • From and Thru dates
   • Member’s Last Name, First Name and MI (all caps)
   • Sex
   • DOB
   • DStat – Discharge Status
   • Bill Type
   • Total Charges
   • Admit/RVDX1 – Diagnosis #1
   • Coder = First Initial/Last Name of Analyst pricing claim (all caps)

3.3 Claims Analyst keys the following fields from the paper claims or MC400 claim into the Webstrat Summary Screen.
   • All diagnosis listed on claim
   • Revenue code with CPT/HCPCS code
   • Number of units
   • Date of Service
   • Billed charges

3.4 Initiate software pricing
3.5 Save claim
3.6 APC pricing generated by Webstrat is transferred to claim in MC400 at claim detail level.
3.7 ‘E’ is used for MAC Pricing.
3.8 Edits generated by Webstrat are keyed into the MC400 claim notes and appropriate details are adjusted with an ‘I’ adjustment reason code for inappropriate billing when no pricing available by line or entire claim.
3.9 Late charges, corrected claims and resubmissions must be completely rekeyed into Webstrat for software to correctly price the claim and save the entire contents of the resubmission.
3.10 Change Webstrat status on MC400 header screen to ‘M’

4. Provider Inquiries and Responses

4.1 First responses to providers questioning an OPPS payment should be to explain that the claim was priced using APC/OPPS methodology and make sure they understand what % of Medicare APC (i.e., 100%, 95%, 90%) they are paid at as each contract could be different.
4.2 Provider inquiries not resolved through explanation in Section 4.1 must be directed to the Senior Claims Analyst handling Medicare claims pricing for research with the possibility of requiring additional assistance from HSS Industries.

5. Quarterly Updates to Software

5.1 IT receives and loads files on to PC in QA room.
5.2 IT notifies System Configuration and Claims when upload is complete.
5.3 System Configuration updates appropriate fee schedules in Webstrat
5.4 Claims enters test data and documents and approves testing and results on Service Request Testing Grid provided by IT
5.5 IT loads software update onto appropriate production PCs in Claims Department

6. Optum Insight Contact Information

6.1 Corporate:
   www.optuminsight.com
   13625 Technology Drive
   Eden Prairie, MN 55344
   Phone: 1-888-445-8745
   Fax: 1-952-833-7201
Department Overview
The Medical Management Department (MMD) is committed to ensuring that the care delivered to our Medicare Advantage beneficiaries is of the highest value (Value = (Quality + Service)/Cost). A comprehensive Medical Management Program, including utilization management and case management activities, is administered by Medical Management Coordinators and Medical Directors. These individuals work directly with Primary Care Physicians, Specialists, and other providers in the Health Alliance provider network who are responsible for coordinating the care of our beneficiaries.

Medical Management Coordinators respond to coverage requests by obtaining all necessary clinical information and applying Medicare criteria. Where Medicare criteria are absent, Medical Management uses clinical medical necessity criteria from nationally respected vendors such as InterQual®, internal medical policies or medical technology reviews based on the latest standards. Decisions made using any criteria are based on the beneficiary’s clinical status and assessment of the local health care delivery system. You can access InterQual and internal medical policies on our website at HealthAlliance.org. A paper copy of any Health Alliance medical or behavioral health criteria may be requested by calling your Provider Relations Specialist.

Access to Services
Health Alliance is committed to providing beneficiaries with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage decisions that result in underutilization of care. We do not give financial inducements or set quotas for issuing denials of coverage or care; nor do we keep statistics identifying individual providers and their denial rate. Utilization decisions made by our Medical Directors, Nurse Coordinators, Pharmacy Coordinators, and Pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to encourage barriers to care and services.

Turnaround Time Frames for Coverage Requests
The time frames explained below are our goals for notifying you of coverage decisions. Medical Management adheres to Medicare regulations and takes into account the medical urgency of each member’s condition. Please note that more time (within Medicare requirements) will be taken if needed to perform a comprehensive review.

Standard (nonurgent) preservice requests: Our goal is to provide coverage decisions within five (5) business days of receiving a complete request that contains all the necessary medical documentation. Requests received after 4 p.m. Monday through Friday or on weekends or holidays are considered received on the next business day.

Expedited (urgent) preservice requests: Our goal is to provide coverage decisions within one (1) business day of receiving a complete request. Please mark requests “urgent” only when there is a need for an expedited review as defined by Medicare, and indicate whether it is the beneficiary requesting or the physician certifying an expedited review. A beneficiary or physician may request an expedited review when either party believes that waiting for a decision under the standard timeframe (i.e., 14 days for preservice review) could place the member’s life, health or ability to regain maximum function in serious jeopardy; and the member believes Health Alliance should arrange for services to be provided (when the member has not already received the services outside the Health Alliance network). If you feel the review should be expedited, please certify that you are requesting an expedited review because applying the standard timeframe could seriously jeopardize the life or health of the beneficiary or the beneficiary’s ability to regain maximum function. Expedited reviews may not be requested for services the member has already received. Expedited reviews may be submitted in writing via fax at 217-337-8440 or by calling the MMD at 217-337-8061.

Please submit complete requests. A complete request includes a Health Alliance request form with all pertinent sections filled in and supporting documentation from the medical record. Please refer to the preauthorization list for the member’s plan to determine which requests always require supporting documentation. Supporting documentation is always helpful in making coverage decisions. If you submit inadequate information, the review may take longer to complete. In some situations when it could benefit the beneficiary, an extension may be initiated. You will receive a
letter explaining the extension time frame and what specific information you will need to provide: the beneficiary will receive a copy of this letter. Once the information is received or the extension time frame is exhausted (whichever is first), we will complete the review and notify you of the coverage decision.

You can greatly impact the time it takes for a review to be completed by supplying complete medical information when submitting a request for coverage and by promptly responding to requests for additional information should the original request be missing something.

Preauthorization

PCP to Specialty Referrals – HMO
The PCP must communicate in-network referrals to in-network specialists. Health Alliance does not need to be notified about in-network referrals; however, referrals to out-of-network or tertiary providers do require preauthorization from Health Alliance. This notification must be done using the Health Alliance Request Form (see page 119).

PCP to Specialty Referrals – PPO
Health Alliance members who are enrolled in the Medicare Advantage PPO plan have in and out-of-network benefits. They can choose to see an out-of-network physician and the benefit will be applied at the out-of-network rate.

Diagnostic Testing and Selected Procedures – HMO/PPO
There are a limited number of tests that require preauthorization. Most requests may be preauthorized by calling the Medical Management Department. InterQual guidelines and medical policies can be viewed on the Health Alliance website at www.healthalliance.org. If the diagnostic test or selected procedure is medically urgent and needs to be performed the same day or the next business day, you may preauthorize by calling the Medical Management Department at 217-337-8061.

Tertiary Center and Out-of-Network Services – HMO
Requests for services from tertiary providers or outside the contracted network of providers require the completion of the Health Alliance Request Form and relevant medical records. These services require prior written authorization from a Health Alliance Medical Director. You may request preauthorization in writing by using the Health Alliance Request Form, or in medically urgent situations, you may call 217-337-8061 to preauthorize these services.

Tertiary Center and Out-of-Network Services – PPO
Health Alliance members who are enrolled in the Medicare Advantage PPO plan have in and out-of-network benefits. They can choose to see an out-of-network physician and the benefit will be applied at the out-of-network rate.

If a Medicare Advantage PPO member wants to go to a participating tertiary center and receive in-network coverage, then the Health Alliance Request Form must be completed and submitted with relevant medical records. These services require prior written authorization from a Health Alliance Medical Director. You may request preauthorization in writing by using the Health Alliance Request Form, or in medically urgent situations, you may call 217-337-8061 to preauthorize these services.

Services That May Not Be Medically Necessary – HMO/PPO
For procedures or services that may not be medically necessary, including but not limited to lesion removals not performed in a physician’s office, skin tags and sclerotherapy, please contact the Medical Management Department for verification of coverage. The Medical Management Coordinator may ask you for chart documentation to assist with the review. These services often cannot be authorized at the time of the phone call and may require Medical Director review.
Medical Management

Travel Care Benefits – HMO
Certain continuity of care services can be authorized if the beneficiary will be out of the service area for up to 90 consecutive days. These services may include, but are not limited to, lab work and services provided in a primary care setting. Travel care benefits must be requested by the PCP prior to the beneficiary leaving the designated service area, and must have prior approval from Health Alliance. Please complete and submit the Health Alliance Request Form. Health Alliance will review the request and, if approved, send a letter to the beneficiary that specifically outlines the covered services. Medical expenses and services beyond what was pre-approved will be subject to review by the Medical Management Department unless the services were urgently needed or emergent. Beneficiaries receiving urgently needed or emergency services when traveling will be assessed the appropriate copayment.

Travel Care Benefits – PPO
If the beneficiary uses a non-contracted provider out-of-network, this will be covered at their out-of-network rate. Preauthorization is not required unless a member is going to use a service that may not be medically necessary.

Inpatient Admissions – HMO/PPO
Health Alliance requires notification for inpatient hospital medical, surgical, and behavioral health stays, whether they are elective or direct admissions. Concurrent on-site or telephonic review is conducted by Medical Management Coordinators during the member’s stay. Medical necessity will always be the determining factor regarding additional inpatient days. We may consult the treating physician to discuss alternate care options at a lower level of care, such as skilled nursing facility, home care, or home infusion.

Inpatient hospitals are required to issue the CMS approved “Important Message from Medicare” notice to Medicare Advantage beneficiaries to notify them of their discharge rights, as well as the process for adjudicating appeals based on those rights. Hospitals are expected to comply with all valid and timely deliver requirements set forth by CMS, including issuing the notice within 2 calendar days of admission, obtaining signature of the beneficiary or representative and providing a copy at that time, as well as delivering a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge. Periodic auditing for compliance may be conducted. More information on these requirements as well as a copy of the current notice is available on the CMS website, http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Skilled Care and Home Health Services
Health Alliance requires preauthorization for skilled care and home health services. Telephonic review is conducted by Medical Management Coordinators frequently during the beneficiary’s course of services.

Skilled care facilities (SNFs) and home health agencies (HHAs) are required by CMS to issue a “Notice of Medicare Non-Coverage” notice to Medicare Advantage beneficiaries to notify them that services are ending, as well as the process for initiating an appeal if a beneficiary disagrees with the decision to discontinue services. Health Alliance will fax a copy of the notice for each beneficiary when the beneficiary is admitted for services, unless we agree to other arrangements for your facility or agency.

SNFs and HHAs are required to:
- Provide regular updates to Medical Management of the beneficiary’s progress and discharge planning activities
- Notify Health Alliance immediately of the anticipated discharge date
- Fill in pertinent date fields on the notice
- Obtain signature of the beneficiary or beneficiary’s representative on the notice at least 2 days in advance of the services ending
- Comply with all valid and timely delivery requirements set forth by CMS
- Fax a copy of both pages of the signed notice to 217-337-8440 within one week of services ending

Periodic auditing for compliance is conducted. More information on these requirements is available on the CMS website, http://www.cms.hhs.gov/MMCAG/.
Denial of Certification
For requests that do not meet medical necessity criteria, a Medical Director reviews all the medical information submitted to make a coverage determination. Additional information is requested if needed. The Medical Director may contact the requesting physician to discuss the case further. When necessary, the Medical Director confers with a board certified specialist. After review of the case facts and Medicare criteria, the Medical Director makes a coverage determination of approval or denial, using his/her medical judgment, experience and skill, as well as professionally recognized medical standards for treatment.

For all denials, the beneficiary, the beneficiary’s representative, and the requesting practitioner are notified in writing of the determination. The denial notice includes the instructions on how the practitioner can contact the Medical Director to discuss the denial. The practitioner may also contact 217-337-8061. Requests for benefits that clearly fall outside Medicare benefits may be denied by the Medical Management Coordinator. Any denial decision for services that are, or that could be considered, covered benefits are determined by the Medical Director as previously described. All appeals are handled by the Member Relations Department (see the Appeals Process section of this manual).

Case Management Program
The Case Management program is on an outpatient basis. Case Management integrates the health team by including the member, the family, physician and ancillary providers in conjunction with the Health Plan. A team effort between all the involved parties allows for better continuity, consistent treatment plan and transition of care from one level to another when indicated. Case Managers assess, coordinate and authorize services for identified high-risk members. This coordination of care includes efforts to identify opportunities for cost-effective treatment while maintaining or improving the quality of services available under the member’s plan. The careful monitoring of these members alerts the Case Manager to changes in health status and allows for proactive communication with the primary care physician or treating physician to provide early intervention, if warranted.

Potential candidates for Case Management are identified in various ways, including predictive modeling software reports, referral from a disease management program, the inpatient care review process and other UM activities. Case Management referrals are also accepted from members, their families, discharge planners, practitioners, providers involved in a member’s care and telephone advisory lines. Once identified, members are contacted and given the opportunity to participate in the program.

Case Managers use evidence-based clinical assessment tools to identify gaps and barriers to care and develop a plan of care specific to the member’s health status, taking into account the individual’s specific needs and goals.

A. Case Managers
   The Case Management program focuses on assisting with coordination of services to ensure the member is receiving the right care, at the right time and right place. This includes acting as a liaison with multiple care providers, members and family. Another focus is educating members on their disease process and lifestyle changes that could impact or slow down the progression of their disease. The Case Management program includes, but is not limited to, the following conditions, diseases or high-risk groups:
   - Acute myocardial infarction
   - Cancer
   - Diabetes
   - Transplants
   - Cardiac and/or lung disease
   - Congestive heart failure
   - Kidney failure/end-stage renal disease
   - Multiple/repeat admissions
   - Multiple chronic illnesses or chronic illnesses that result in high utilization
   - Neurological syndromes
   - Pediatric anomalies
Case Managers work with the member to develop an individualized plan of care, including:

- Prioritized goals
- Identification of barriers to meeting goals, participating in or complying with the plan
- The development and communication of member self-management plans
- The development of a schedule for member follow-up and re-evaluation timeframes
- An assessment of the member’s progress toward overcoming barriers to care and meeting treatment goals
- Elicit the involvement of the member, family member, caregiver and/or providers in problem identification and prioritization, as needed
- Provide education related to specific conditions or disease states, health maintenance and prevention
- Explore community resources available to the member
- Encourage member to communicate changes in condition with the attending physician
- Provide guidance to members and families in phases of adjustment to acute, chronic or terminal illness
- Maintain communication with the member and/or family to assure that the member understands, and is benefiting from, the care being received
- Advise attending physician(s) of any significant status changes

B. Quality Program

The Medical Management Department collects and analyzes data in support of the Quality Management Program for the following initiatives: Case Management outcomes, continuity and coordination of care, quality of care and patient safety.

Satisfaction Survey

On an annual basis, the Medical Management Department surveys a sample of our providers to evaluate your satisfaction with our Medical Management processes such as inpatient care coordination, case management, preauthorization, referral review, timeliness of decision making and communication. The results are analyzed for ways we can improve provider satisfaction. Your participation is greatly appreciated.

How to Get More Information

If you have questions about the status of a review or any other Medical Management process or would like to refer a member to our program, call Health Alliance during normal business hours, Monday-Friday, 8 a.m. to 5 p.m., at 1-800-965-4022. After normal business hours, you may leave a message at this number, and it will be returned the next business day. You can also send questions via fax at any time to your local Medical Management Department office, or to 217-337-8440.
## REQUEST FORM

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

<table>
<thead>
<tr>
<th>Reason for Request:</th>
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<tbody>
<tr>
<td>❑ Not Available in Network</td>
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<tr>
<td>❑ Other [please specify]</td>
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### Date

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Health Alliance ID Number</th>
<th>Patient Birthdate</th>
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<tr>
<th>Requesting Physician’s Name</th>
<th>Requesting Physician’s Phone Number</th>
<th>Requesting Physician’s Fax Number</th>
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<tr>
<th>Diagnosis Code:</th>
<th>Diagnosis:</th>
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<th>Procedure Code:</th>
<th>Procedure:</th>
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- ❑ Inpatient Procedure (services provided may result in admission)

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<tr>
<th>Facility</th>
<th>Practitioner</th>
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<th>Provider Phone Number</th>
<th>Provider Fax Number</th>
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**Physician Signature**

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### Tertiary/Out-of-Network Referrals

**Referred to:**

<table>
<thead>
<tr>
<th>Physician</th>
<th>Facility</th>
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<table>
<thead>
<tr>
<th>Physician Phone Number ( )</th>
<th>Physician Fax Number ( )</th>
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</table>

**Service Reason:**

- ❑ Consult
- ❑ Consult and Treatment

- ❑ The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

**Physician Signature**

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<th>Date</th>
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### Pharmacy Medical Exception/Rx Preauthorization  (Fax to 217-255-4598)

**Drug Requested**

<table>
<thead>
<tr>
<th>Strength</th>
<th>Diagnosis</th>
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1)

2)

3)

**Physician Signature**

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<th>Date</th>
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**Completion of all fields is required.**

- ❑ URGENT REQUEST
  - Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient’s life/health, or the patient’s ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

- ❑ Medical Management Department
  - Fax 217-337-8440

- ❑ Pharmacy Department
  - Fax 217-255-4598

- ❑ Tertiary/Out-of-Network Referrals
  - Fax 217-255-4598

- ❑ Pharmacy Medical Exception/Rx Preauthorization
  - Fax 217-337-8440

- ❑ Pharmacy Medical Exception/Rx Preauthorization
  - Fax 217-255-4598

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**Health Alliance • 301 S. Vine St. • Urbana, Illinois 61801**

217-337-8061 • Fax 217-337-8440

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**com-refmrv3-0313**
Pharmacy Benefits

Prescription Drug Benefit Administration
Health Alliance Medicare administers pharmacy benefits in conjunction with MedImpact, a pharmacy benefit management company. This function is coordinated by the Pharmacy Department at Health Alliance. Activities of this department include:

- Pharmacy network development and maintenance
  - Contracting
  - Monitoring/auditing
- Third-party claims processor relations, contract development and management
- Manufacturer discount contracting
- Pharmacy & Therapeutics Committee support
- Medical Management Department clinical support
- Medical Directors Committee and Administrative support
- Quality Improvement Committee support
- Pharmacy utilization reporting and physician support
- Customer Service Department and Claims Department support
- Medicare Part D Formularies coordination and management
Prescription Plan Options
Health Alliance offers several Medicare plans effective January 1, 2015. To view complete Medicare Formularies go to HealthAllianceMedicare.org.

Illinois Formularies
• Medicare Advantage HMO/PPO/PDP Formulary (used with all Illinois plans)

Nebraska and Pottawattamie County, IA Formulary
• Guide HMO Formulary (used with Guide Rx HMO plan)

Washington Formulary
• Companion HMO Formulary (used with Companion Rx HMO and Companion Plus Rx HMO)

Beneficiaries with low incomes, who live in long-term care facilities or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact Health Alliance for details.

See the following four pages for pharmacy benefit highlights.
**Initial Coverage**

After you pay your yearly deductible for drugs on Tiers 3-5, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

<table>
<thead>
<tr>
<th>Plan Options</th>
<th>Rx Deductible on Tiers 3-5</th>
<th>Rx Cost by Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HMO BasicRx</td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td>HMO 40Rx</td>
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<td>$10</td>
</tr>
<tr>
<td>HMO 20Rx</td>
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<td>$10</td>
</tr>
<tr>
<td>PPO BasicRx</td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td>PPO 30Rx</td>
<td>$0</td>
<td>$10</td>
</tr>
<tr>
<td>PPO 10Rx</td>
<td>$0</td>
<td>$10</td>
</tr>
</tbody>
</table>

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**Coverage Gap**

The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45 percent of the plan’s cost for covered brand name drugs and 65 percent of the plan’s cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700.

You pay the greater of:
- 5 percent of the cost, or
- $2.65 for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

Call toll-free 1-888-382-9771, TTY/TDD 711.
8 a.m. to 8 p.m. daily October 1 to February 14,
8 a.m. to 8 p.m. weekdays the rest of the year. HealthAllianceMedicare.org

**Extra Help**

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call:
- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/seven days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.
# 2015 Illinois Stand-Alone Prescription Drug Plan (PDP) Benefits

If you have any questions about this plan’s benefits or costs, please contact Health Alliance Medicare Prescription Plan for details.

## SECTION II – SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Health Alliance Medicare Prescription Plan - Basic (PDP)</th>
</tr>
</thead>
</table>

### MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| How much is the monthly premium? | $75.90 per month. |
| How much is the deductible? | $320 per year for Part D prescription drugs. |

Health Alliance Medicare is a Prescription Drug plan with a Medicare Contract. Enrollment in Health Alliance Medicare Prescription Drug Plan - Basic (PDP) depends on contract renewal.

### PRESCRIPTION DRUG BENEFITS

**Initial Coverage**

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail-order pharmacies.

#### Preferred Retail Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$17 copay</td>
<td>$34 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45 copay</td>
<td>$90 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$95 copay</td>
<td>$190 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>25% of the cost</td>
<td>25% of the cost</td>
</tr>
</tbody>
</table>

#### Standard Retail Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$1.50 copay</td>
<td>$4.50 copay</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$17 copay</td>
<td>$51 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45 copay</td>
<td>$135 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$95 copay</td>
<td>$285 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>25% of the cost</td>
<td>25% of the cost</td>
</tr>
</tbody>
</table>
Pharmacy Benefits

2015 RX BENEFITS

Health Alliance Medicare Advantage plans come with built-in prescription coverage.

### Initial Coverage*
After you pay your yearly deductible for drugs on Tiers 3-5, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

<table>
<thead>
<tr>
<th>Plan Options</th>
<th>Tier 1 Rx at Walmart and Sam's</th>
<th>Rx Cost by Tier</th>
<th>Rx Deductible on Tiers 3-5</th>
<th>Rx Cost by Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guide Rx HMO</td>
<td>$0</td>
<td>$8</td>
<td>$33</td>
<td>$70</td>
</tr>
<tr>
<td>Guide HMO Plus Rx</td>
<td>$0</td>
<td>$8</td>
<td>$33</td>
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</tr>
<tr>
<td>Guide PPO Rx</td>
<td>$0</td>
<td>$8</td>
<td>$33</td>
<td>$40</td>
</tr>
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### Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700.

You pay the greater of:
- 5 percent of the cost, or $2.65 for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

### Extra Help
You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call:
- 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048, 24 hours a day/seven days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

Call toll-free 1-877-925-0424, TTY/TDD 711. 8 a.m. to 8 p.m. daily October 1 to February 14, 8 a.m. to 8 p.m. weekdays the rest of the year. HealthAllianceMedicare.org
You can add pharmacy benefits to any Medicare HMO plan.

**Initial Coverage**
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<tbody>
<tr>
<td></td>
<td></td>
<td>No Deductible</td>
<td>Deductible</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Companion Rx HMO</td>
<td>$0</td>
<td>$8</td>
<td>$33</td>
<td>$70</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Companion Plus Rx HMO</td>
<td>$0</td>
<td>$8</td>
<td>$33</td>
<td>$20</td>
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<td></td>
<td></td>
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- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/seven days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

Call toll-free 1-877-561-1463, TTY/TDD 711. 8 a.m. to 8 p.m. daily October 1 to February 14, 8 a.m. to 8 p.m. weekdays the rest of the year. HealthAllianceMedicare.org
Pharmacy Benefits

**Medicare Part D Formularies**
The Health Alliance Medicare Part D Formularies were created to assist in the management of ever-increasing costs of prescription medications. The use of formularies to provide physicians with a reference for cost-effective medical treatment has been used successfully in health insurance organizations throughout the country.

The Medicare Part D Formularies were created under the guidance of physicians and pharmacists representing most specialties. The Pharmacy and Therapeutics Committee (P&T) evaluates the needs for most patients, use of products, and cost-effectiveness as factors to determine the formulary choices. In all cases, available bioequivalency data supply and therapeutic activity are considered.

The P&T Committee meets on a regular basis to evaluate the changing needs of physicians and patients. We urge you to provide recommendations for improvement of the Medicare Part D Formulary and its contents. It is our belief that the Medicare Part D Formulary can enhance your ability to provide quality, cost-effective care to your Health Alliance patients.

The use of products on the Medicare Part D Formularies is encouraged as a method to provide quality care at a lower cost. If a pharmacist receives a prescription for a Tier 4 drug, the prescription will be assessed at the highest copayment* tier, e.g., $95.

The use of generic products is highly recommended where applicable.

To reach the Health Alliance Pharmacy Department, please call 1-800-851-3379, option 4. To view our formulary online, visit HealthAllianceMedicare.org and choose “Medicare Part D Formulary” from the left-hand menu. To search within the PDF document, choose the search function (the picture of binoculars), enter a drug name and click “search.”

* Beneficiaries who qualify for extra help with their prescription costs through State or Federal programs may have different copayment amounts.

**Changes to the Medicare Part D Formularies**
There are currently several thousand medications, combinations of medications and dosage forms available in the United States. Inclusion of all of the products would compromise the ability of the formulary to control cost and optimize patient care.

The P&T Committee can add/change a product with a majority vote. A product may be tabled for the next meeting if more information is needed.

The additions/changes of drugs to the formulary will be based on a comparative efficacy, pharmacoeconomic data and drug-specific parameters such as side effect profiles, pharmacokinetics and contraindications. Evaluations will be based on information from peer-reviewed medical references, primary literature and standard of practice guidelines. Cost will be considered a major factor in making additions/changes to the formulary when little or no difference exists in comparative and drug specific parameters. Specific considerations are listed below:

**Proper Indication**
The medication must have an indication that would benefit patients in an ambulatory/outpatient setting.

To better meet the needs of our members, we have switched the Health Alliance Medicare formulary to an open formulary. An open formulary allows for some drugs that are not specifically listed in the formulary to still be covered.
The open formulary is separated into four tiers: Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5. Tier 1 drugs require the lowest copayment because they are the most cost-effective. Unless excluded by Medicare or not on the Health Alliance Formulary, specialty medications are listed on the formulary as Tier 5.

**Efficacy**
The medication must be clearly proven as effective in the outpatient population. It must also offer a distinct advantage over existing products in the same therapeutic category. These advantages must include, but are not limited to:

- Distinct or unique therapeutic feature
- Greater efficacy against other products in the same therapeutic category that can be clearly shown in clinical trials
- Improved dosing schedule, decrease in adverse effects, or fewer contraindications which clearly show superiority over existing products
- Cost savings over products in the same therapeutic category

**Information**
Decisions from the P&T meeting will be communicated to all physicians in our electronic newsletter *inforMED*. You can view the updated Medicare Part D Formulary at HealthAllianceMedicare.org.

**General Exclusions of the Medicare Part D Formularies**
The following are not covered:

- A. Over-the-counter (OTC) medications or their equivalents
- B. Any drug products not listed in the Medicare Part D Formulary or specifically listed as not covered
- C. Experimental drug products or any drug product used in an experimental manner
- D. Replacement of lost or stolen medication
- E. Foreign drugs or drugs not approved by the United States FDA
- F. Anorexics or drugs for weight loss or gain
- G. Fertility agents
- H. Agents for hair growth
- I. Agents of symptomatic relief from cough and colds
- J. Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
- K. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
- L. Medical supplies and items not considered drugs
- M. Erectile dysfunction drugs

**Voluntary Pharmacy Programs**
You can help your patients save money on prescription drugs by encouraging participation in our voluntary pharmacy programs. If you have any questions, or want to verify a beneficiary’s eligibility for any of the following programs, please contact the Health Alliance Pharmacy Department at 1-800-851-3379, option 4.
Innovative Pharmacy Initiatives

Health Alliance Medicare voluntary pharmacy programs offer convenience and savings. Please note: Not all Health Alliance plans include the following programs. Please contact Health Alliance Medicare Services to verify eligibility.

Mail-Order Convenience
Most members with a pharmacy benefit can receive home delivery of prescription drugs with the Health Alliance Medicare mail-order program through Walgreens.

Online Prescription Assistance
Members can view their actual pharmacy claims and copayment information specific to their plans on our website. They can compare cost and drug information for medications similar to theirs.

Visit www.healthalliance.org and log in. Next, click on “Member Services” and then “My Drug Benefit.”

Features allow you to:
- See the cost to have a new prescription filled.
- Review information on any drug, including side effects and interactions.
- Locate a pharmacy close to your home, school or office.

Preferred Pharmacy Program

$0 Copayment at Walmart/Sam’s Club
Members with pharmacy coverage get Tier 1 prescription drugs at Walmart and Sam’s Club for $0. Tier 1 Preferred Generics include most generic medications. Though Walmart and Sam’s Club are Preferred Pharmacies, members can receive drugs at any of our in-network pharmacies.

Also at Walmart and Sam’s Club, take advantage of Choice90Rx*. Get three months of your medications for two copays.

* 90-day supplies available at other pharmacies for a different copay.
**Standard Appeal**

If a beneficiary, physician, legal representative or authorized representative does not agree with a decision made by Health Alliance, he or she may appeal.

If a member decides to proceed with the standard appeals/reconsideration process, the following steps will occur:

1. A **written request** for a reconsideration of the decision must be submitted to Health Alliance within 60 days from the date of denial notice from Health Alliance Medicare, Attn: Member Relations Coordinator, 301 South Vine Street, Urbana, IL 61801-3347, or by fax to 217-337-8009. Requests for an appeal may also be sent to the Social Security Administration office (or, if a beneficiary is a railroad retirement beneficiary, to a Railroad Retirement Benefits office). Please note that if the Social Security Administration office or the Railroad Retirement Board office receives a written request for an appeal, they will forward the request to us. Therefore, the time frame within which we must conduct our review begins when we receive the request.

2. Health Alliance will conduct a reconsideration of the decision and notify the beneficiary in writing of the decision, using the following time frames:

   **Request for Service.** If the appeal is for a denied service, we must notify the beneficiary of the reconsideration decision as expeditiously as the beneficiary’s health requires, but no later than 30 days after we receive the appeal. We may extend this time frame by up to 14 calendar days if the member requests the extension or if we justify the need for additional information and how the extension of time benefits the beneficiary (for example, if we need additional medical records from non-contracted providers that could change a denial decision). Again, we must make a decision as expeditiously as the beneficiary’s health requires, but no later than the end of any extension period. When we take an extension, the beneficiary will be notified of the extension in writing. If the beneficiary disagrees with our decision to take an extension, the member can file a grievance.

   **Request for Payment.** If the appeal is for a denied claim, we must notify the beneficiary of the reconsideration determination no later than 60 days after receiving the request for a reconsideration determination.

   Please note: Our reconsideration decision will be made by a medical director not involved in the initial decision. All reconsiderations of adverse organization determinations based on “lack of medical necessity” must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue. However, that physician need not be of the same specialty or subspecialty as the treating physician. The beneficiary or another authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing to Health Alliance.

3. If we decide fully in the beneficiary’s favor on a request for service, we must provide or authorize the requested service as expeditiously as the beneficiary’s health requires, but no later than 30 calendar days from the date we received the request for reconsideration (or no later than upon expiration of an extension). If we decide fully in the beneficiary’s favor on a request for payment, we must make the requested payment within 60 days of the date we received the request for reconsideration.

4. If we decide to uphold our original adverse decision, either in whole or in part, or if we fail to provide a decision on a beneficiary’s reconsideration within the relevant time frame, we will automatically forward the case file to an independent review entity for a new and impartial review. Maximus Federal Services is the current independent review entity contracted by CMS to review appeals involving Medicare Advantage organizations like Health Alliance. We must send Maximus Federal Services the file within 30 days of a request for service and within 60 days of a request for payment. Maximus Federal Services will either uphold or reverse our decision. If we forward the case to Maximus Federal Services, we still must notify the beneficiary of our decision within the relevant time frames discussed above.
For cases submitted for review, Maximus Federal Services will make a reconsideration decision and notify the beneficiary in writing of their decision and the reasons for the decision.

5. If Maximus Federal Services decides in the beneficiary’s favor and reverses our decision, the following must occur:

Request for Service. If Maximus Federal Services decides in the beneficiary’s favor, we must authorize the service under dispute within 72 hours of the date we receive Maximus Federal Services’ notice reversing our decision, or provide the service under dispute as expeditiously as the beneficiary’s health condition requires, but no later than 14 calendar days from the date of Maximus Federal Services’ notice.

Request for Payment. If Maximus Federal Services decides in the beneficiary’s favor, we must pay for the service no later than 30 calendar days from the date we receive Maximus Federal Services’ notice reversing our decision.

If Maximus Federal Services does not rule fully in the beneficiary’s favor, there are further levels of appeal.

6. If the dollar threshold given by Maximus Federal Services is met, a beneficiary may request a hearing before an administrative law judge (ALJ) by submitting a written request to the entity specified in the Independent Review Entity (IRE) reconsideration notice within 60 days. (This 60-day notice may be extended for good cause.) If a request for an ALJ hearing is submitted to us or to the Social Security Administration, we will forward it to Maximus Federal Services. Maximus Federal Services will then forward the ALJ hearing request and reconsideration file to the ALJ hearing office. Health Alliance will also be made a party to the appeal at the ALJ level.

7. If the member or Health Alliance disagrees with the ALJ’s decision, either may request a review of an ALJ decision by the Medicare Appeals Council (MAC), which may either review the decision or decline review.

8. If the dollar threshold given by the ALJ is met, either the member or Health Alliance may request judicial review if a decision has been made by the MAC or if the MAC has declined review of the ALJ’s decision.

9. Any initial or reconsidered decision can be reopened by the entity that made the decision (that is, Health Alliance, CHDR, the ALJ or the MAC). Reopenings initiated by Health Alliance or the member may request a reopening within one year from the date of the organization determination or reconsideration for any reason, within four years for good cause. An IRE, ALJ or MAC may reopen within 180 days from the date of reconsideration for good cause.

Unless it is reopened, the reconsidered determination is final and binding upon the Medicare Advantage organization. If the dispute involves a benefit determination, the Medicare Advantage organization cannot offer any other dispute resolution process except what is required by law.

**Expedited Review Request Process**

1. Upon receiving a request for an expedited decision, Health Alliance will determine if the request meets the definition of time-sensitive.

If the request for an expedited organization determination does not meet the definition, it will be handled as expeditiously as the beneficiary’s health requires, but no later than 14 calendar days after receiving the expedited request for service.

If a request for an expedited appeal does not meet the definition, it will be handled as expeditiously as the beneficiary’s health requires, but no later than 30 calendar days after we receive the expedited appeal request.

The beneficiary will be informed by telephone or in person whether the request will be processed through the expedited/72-hour review or the standard review process and will also be sent a written confirmation within three calendar days of the phone call or personal contact.
If the beneficiary disagrees with Health Alliance to process his or her request within the standard time frame, a grievance may be filed with Health Alliance. The written confirmation letter will include instructions on how to file a grievance.

An extension up to 14 calendar days is permitted for a 72-hour request for organization determination/appeal if the beneficiary asks for the extension or we need more information and the extension of time benefits the beneficiary (for example, if you need time to provide us with additional information or if we need to have additional diagnostic testing completed).

2. The request must be processed as expeditiously as the beneficiary’s health requires, but no later than 72 hours if any physician calls or writes in support of the request for an expedited/72-hour review (unless an extension is granted), and the physician indicates that applying the standard review time frame could seriously jeopardize the beneficiary’s life, health or ability to regain maximum function.

3. Health Alliance will make a decision on the request for an organization determination or appeal and notify the member of a decision within 72 hours of receipt of the request.

When the beneficiary requests an expedited determination/appeal, if the beneficiary does not hear from us within 72 hours of the request, it can be assumed the request has been denied. For an expedited determination, our failure to notify the member in a timely manner—within 72 hours—constitutes a denial, which you may appeal. For an expedited appeal, if we fail to notify the beneficiary in a timely manner—within 72 hours—the request will automatically be forwarded to Maximus Federal Services.

4. If, on reconsideration of decision, Health Alliance decides fully in the beneficiary’s favor on a request for service, we must authorize or provide the requested service under dispute as expeditiously as the beneficiary’s health condition requires, but no later than 72 hours after we receive the request for a reconsideration (or no later than upon expiration of an extension discussed above).

5. If we decide to uphold the original adverse decision, either in whole or in part, we will forward the entire case file to Maximus Federal Services for an impartial review as expeditiously as the beneficiary’s health requires, but no later than 24 hours after our decision. Maximus Federal Services will send the beneficiary a letter with their decision within 72 hours of receiving the case from us or at the end of up to a 14-calendar-day extension.

If Maximus Federal Services decides in the beneficiary’s favor and reverses our decision, we must authorize or provide the service under dispute as expeditiously as the beneficiary’s health condition requires but no later than 72 hours from the date we receive Maximus Federal Services’ notice reversing our decision.

If Maximus Federal Services does not rule fully in the beneficiary’s favor, there are further levels of appeal as discussed above.

**Expedited/72-Hour Review**

If a beneficiary, physician, legal representative or authorized representative believes the beneficiary continues to need a service and believes it is a time-sensitive situation, a request for the decision to be expedited may be made. If Health Alliance decides that it is a time-sensitive situation or if any physician states that it is one, we will make a determination on the request for service on an expedited/72-hour basis.

If Health Alliance denies a beneficiary’s request for a service, the beneficiary, physician, legal representative or authorized representative may choose to submit a written or oral appeal under the expedited appeal process if the beneficiary’s health could be seriously harmed by waiting 30 days for the standard appeals process.
To proceed with the expedited/72-hour review process, the following steps should occur:

If any physician asks for an expedited appeal or supports the member in asking for one, we will automatically make a decision on the appeal on an expedited/72-hour basis.

We may extend this time frame by up to 14 calendar days if the beneficiary requests the extension or if we need additional information, and the extension of time benefits the beneficiary (for example, if we need additional medical records from non-contracted providers that could change a decision). Again, we must make a decision as expeditiously as the beneficiary’s health requires, but no later than the end of any extension period.

If an expedited appeal is requested without support from a doctor, we will decide if the beneficiary’s health condition requires us to make a decision on an expedited basis. If we do not approve the expedited appeal request, we will notify the beneficiary verbally followed by written confirmation within three calendar days that we will process the appeal request as a standard appeal. If the beneficiary disagrees with our decision not to grant an expedited appeal, the beneficiary can file a grievance with us.

Examples of service decisions for which a member may request an expedited/72-hour appeal include the following:
- The beneficiary received a denial of a proposed service.
- The beneficiary thinks services are being discontinued too soon.
- The beneficiary thinks he or she is being discharged from a skilled nursing facility too soon.
- The beneficiary thinks his or her home health care is being discontinued too soon.
- The beneficiary thinks he or she is being discharged from a Hospital too soon, and has missed the deadline for a Quality Improvement Organization (QIO) review.

The procedures for requesting an expedited organization determination or an expedited appeal are described below. Please note that the expedited procedures do not apply to requests for payment of services already furnished.

To request an expedited/72-hour review for a beneficiary, you can call, write or fax. You must ask for an expedited/72-hour review when you make your request.

**Call:** 1-800-500-3373, available 24 hours a day, seven days a week

**TDD/TTY:** 217-337-8137
8 a.m. to 5 p.m., Monday through Friday

**Write:** Health Alliance Medicare
Attn: Member Relations Coordinator
301 S. Vine St.
Urbana, IL 61801-3347

**Fax:** 1-800-337-8009
Attention: Member Relations Coordinator
8 a.m. to 5 p.m., Monday through Friday

**Fast Track Appeals Review**
Members receiving skilled services in home health settings or at a skilled nursing facility or a comparable outpatient rehabilitation facility will be issued a discontinuation letter. This letter will be faxed to the provider of service with the expectation that the provider will hand deliver the letter to the member or their representative. The letter of notice of medical non-coverage is required by the Center of Medicare and Medicaid Services (CMS) to be given no later than two days before coverage of services will end. The beneficiary or the beneficiary’s representative needs to have the
signature page returned to the health plan within 24 hours of delivery. If services are expected to be fewer than two days, the letter must be delivered upon admission.

- If the beneficiary, provider, legal representative or authorized representative decides to file a fast track appeal, they have until noon of the day before services are to end to do so after they have been notified by the health plan. The NOMNC letter will have the telephone number where the call needs to be placed to initiate the appeal. **Note: If the noon deadline is missed, the appeal can still be requested through the Expedited/72 Hour Review. The telephone number will also be listed on the NOMNC letter.**

- If a “Fast Track” appeal had been registered with the Quality Improvement Organization (QIO) the Member Relations staff will be notified of the appeal and all relevant medical information needed to review the appeal will be forwarded to the QIO. If needed, the provider will be contacted by Member Relations staff at Health Alliance to ask for assistance in faxing the QIO medical records or delivering information to the beneficiary.

- Once the QIO has made a decision on the appeal, they will notify the party registering the appeal, facility and Medicare Advantage of the decision by phone and in writing. In the event the appeal is in favor of the beneficiary, Medicare Advantage will also send to the appealing party and facilitate a letter of approval.

**Beneficiary Appeals Process**
Below is the process beneficiaries follow to file an appeal:

1. You may file an appeal or have someone else file the appeal for you on your behalf. Any physician may file an expedited appeal on your behalf.

2. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:
   a. Give us your name, your Medicare number and a statement, which appoints an individual as your representative. For example: I _[your name]_ appoint _[name of representative]_ to act as my representative in requesting an appeal from the Medicare Advantage Organization and/or the Centers for Medicare & Medicaid Services regarding the denial or discontinuation of medical services.
   b. You must sign and date the statement.
   c. Your representative must also sign and date this statement unless he/she is an attorney.
   d. You must include this signed statement with your appeal.

3. A non-contracting physician or other provider who has furnished you a service may file a standard appeal of a denied claim if he/she completes a waiver of payment statement which says he/she will not bill you regardless of the outcome of the appeal.

**Supporting Your Appeal**
Health Alliance is responsible for gathering all necessary medical information relevant to your request for reconsideration (appeal). However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a specialist are not included in your medical records from your Primary Care Physician, you may need to make a separate request to the specialist who provided medical services to you.

You have the opportunity to provide additional information in person or in writing. In the case of an expedited decision or appeal, you or your authorized representative may submit evidence in person, by telephone or in writing transmitted
Appeals Process

by fax at the address and telephone number referenced above under the expedited/72-hour review procedure. (Please call Health Alliance if you need additional information or help understanding the procedures for submitting evidence to support your appeal.)

Assistance With Appeals
Regardless of whether you file a standard appeal or ask for an expedited review, you can have a friend, lawyer or someone else help you. Health Alliance Medicare Services is available to help you between the hours of 8 a.m. and 5 p.m., Monday through Friday. Call toll-free 1-800-965-4022. Beneficiaries using TTY, please dial 217-337-8137. There are lawyers who may be willing to not charge a fee unless you win your appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, that will give you free legal services if you qualify. You may want to contact The Medicare Rights Center at 1460 Broadway, New York, NY 10036, or call toll-free 1-888-HMO-9050 from 12 p.m. to 2 p.m. EST, Monday through Thursday.

If you have questions regarding these rights, please call our Member Services Department toll-free at 1-800-965-4022. Beneficiaries using TTY, please dial 217-337-8137. Hours of operation are 8 a.m. to 5 p.m., Monday through Friday.

Maximus Federal Services Reopening
A reopening is not an appeal right. Any of the parties to a reconsidered determination may request a reopening; however, granting a reopening is solely at Maximus Federal Services’ discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made.

All Maximus Federal Services determinations advise the parties of the standards for reopening of the case file by Maximus Federal Services. A reopening may be requested by any party to the determination if the party believes one of the following grounds for reopening is applicable:

• Error on the face of the evidence by Maximus Federal Services in its review
• Fraud
• New and additional information that was not available at the time Maximus Federal Services made its initial determination in the case

A Medicare Advantage organization’s request for a reopening does not relieve the Medicare Advantage organization of the responsibility to comply with Maximus Federal Services’ decision within the required time frames.

Appeal Process—Medicare Part D
A member or their representative can appeal our decision not to cover a drug, vaccine or other Part D benefit. They may also appeal our decision not to reimburse for a Part D drug that has been paid for. The member can appeal if they think we should have reimbursed them more than they received or if they asked us to pay a different cost-sharing amount than they thought they are required to pay for a prescription. Finally if we deny the Exception request the member can appeal.

If a request is denied, the member and providers involved with the coverage will receive a written decision explaining the reason why the request was denied. We may decide completely or partly against the request.

If we deny part or all in our coverage decision, the member or member’s representative may ask us to reconsider our decision. The member, member’s representative or the prescribing doctor may file a fast appeal. The request may be made in person, by phone, fax or in writing. If the appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, the doctor and member will first need to decide whether the member needs a fast appeal.

The appeal must be filed within 60 calendar days from the date included on the notice of your coverage determination. We can give more time if there is a good reason for missing the deadline.
For a fast appeals the member, member’s representative of prescribing doctor can ask us for a fast appeal (rather than a standard appeal) by calling 1-800-500-3373 (for TTY, call 1-800-526-0844) or you can call fax at request to 217-337-8009 or deliver in person or send the request to Health Alliance Medical Plans, 301 South Vine Street, Urbana, Illinois 61801-3347. Be sure the request indicates a “fast,” “expedited,” or “72-hour” review. Remember, that if the prescribing doctor provides a written or oral supporting statement explaining that there is a need for the fast appeal, we will automatically treat the request as a fast appeal.

If the request is for a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug the member has already paid for and received, we have up to 7 calendar days to give a decision, but will make it sooner if the health condition of the member requires us to. If we do not make the decision within 7 calendar days, the request will automatically be submitted to an independent organization and they will review the request.

If the decision is approved in favor of the member, we must send payment to the member no later than 30 calendar days after we receive tour request for reconsideration.

If the request is for a fast decision about a Part D drug that you have not received we have up to 72 hours to give a decision, but will make it sooner if the health condition of the member requires us to. If we do not make the decision within 72 hours, the request will automatically be submitted to an independent organization and they will review the request.

If the decision is approved in favor of the member, we must provide the Part D drug within 72 hours of receiving the appeal or sooner, if the member’s health would be affected by waiting this long.

If we deny any part of the appeal the member or member’s representative may ask for a review by a government-contracted independent review organization. The independent review organization is an outside independent organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has not connection with us. The member has a right to ask us for a copy of the case file we sent to this organization.

The member or appointed representative are the only ones allowed to make a request for review by the independent review organization in writing within 60 calendar days after the date the member was notified of the decision on the 1st appeal review. The written request must be sent to the address included in the redetermination letter from Health Alliance. If the request asks for a fast review and there is a prescribing doctors written or oral statement explaining the need for a fast appeal, the independent review organization will automatically treat the appeal as a fast appeal.

For standard independent review the organization has 7 calendar days from the date it received the appeal request to make a decision. For a fast independent review the organization has 72 hours from the date it received the appeal request to make a decision. The independent review organization will tell the member and prescribing doctor in writing about its decision and reasons for it.

If the decision is about reimbursement for a Part D drug the member has already paid for and received, we must pay within 30 calendar days from the date we receive notice reversing our coverage determination. If the decision is about a standard Part D drug the member has not received we must authorize or provide the member with the Part D drug within 72 hours from the date we receive notice reversing our coverage decision. If the decision was a fast decision about a Part D drug we have 24 hours from the date we received notice reversing our coverage decision. With all reversals we will send to the organization notice that we abided by their decision.

If the independent review organization upholds our denial the parting filing the appeal will be notified in the decision letter of any other appeals levels available for continued review.

If you would like a copy of the Appeals policy, contact the Member Relations Department at 1-800-500-3373.
**Overview**

Beneficiaries use the following Health Alliance grievance procedure for complaints that do not involve coverage decisions such as those set forth in the appeals section of this book.

Medicare Advantage plan beneficiaries have the right to file a complaint—also called a grievance—about problems they have, including:

- complaints about the quality of services received;
- complaints about issues such as office waiting times, physician behavior, adequacy of facilities or other similar beneficiary concerns;
- involuntary disenrollment situations;
- if they disagree with our decision to process a request for a service or to continue a service under the standard 14 calendar day time frame rather than the expedited/72-hour time frame; and
- if they disagree with our decision to process an appeal request under the standard 30-day time frame rather than the expedited/72-hour time frame.

To use the formal grievance procedure, a beneficiary can send his or her grievance in writing to the Health Alliance Medicare Services. We will respond to the beneficiary to let him or her know how we have addressed the concern as expeditiously as the enrollee’s case requires, based on the enrollee’s health status, but no more than 30 days after the date the health plan receives the written or oral grievance. Grievances filed orally may be responded to orally unless the enrollee requests a written response or the grievance concerns quality of care. Grievances in writing will be responded to in writing.

In some instances, we need additional time to address concerns. If additional time is needed, we keep the beneficiary informed of how the grievance is being handled. Whether the formal (written) or informal (telephone) grievance procedure is used, we must keep track of all appeals and grievances in order to report data to CMS and to our beneficiaries, upon request.

Complaints about a decision regarding payment for or provision of covered services that beneficiaries believe are covered by Original Medicare and should be provided or paid for by Health Alliance must be appealed through the Health Alliance Medicare appeals procedure.
**Overview**
Health Alliance supports a beneficiary’s right to express preferences about his or her medical care through “advance directives.”

An advance directive is a written statement or document completed by a person in advance of serious illness about how the person wants his or her health care decisions made. There are two types of advance directives: a “living will” and a “durable power of attorney for health care.”

A living will allows a person to state in advance what types of medical treatments are desired in the event the person develops a terminal illness. A durable power of attorney for health care permits a person to name someone to make health care decisions for him or her if he or she is unable to do so.

If a beneficiary chooses to have an advance directive, he or she should give a copy to your office to be included as part of his or her current medical record. A lawyer or a family member should also know about the beneficiary’s advance directive and its location. A beneficiary may change or cancel these documents at any time. Any change should be written, signed and dated, and copies given to all who may have copies of the original.

Contracted providers are obligated to honor any advance directive a beneficiary initiates.

Beneficiaries are not required to initiate an advance directive and will not be denied care without an advance directive.

Beneficiaries can obtain more information about advance directives by referring to the booklet entitled “Planning Ahead,” which is provided with their other beneficiary materials. We also encourage beneficiaries to contact their attorney, local hospital or any of the following sources for assistance in planning an advance directive:

### Illinois

<table>
<thead>
<tr>
<th>Illinois Department on Aging</th>
<th>Illinois Attorney General</th>
<th>Land of Lincoln Legal Assistance Foundation, Incorporated</th>
</tr>
</thead>
<tbody>
<tr>
<td>421 E. Capitol Avenue</td>
<td>Springfield Main Office</td>
<td>Executive Director’s Office</td>
</tr>
<tr>
<td>Springfield, IL 62701</td>
<td>500 South Second Street</td>
<td>8787 State Street, Suite 201</td>
</tr>
<tr>
<td>Senior Help Line: 1-800-252-8966</td>
<td>(217) 782-1090</td>
<td>East St. Louis, IL 62203</td>
</tr>
</tbody>
</table>

### Iowa

<table>
<thead>
<tr>
<th>Iowa Aging</th>
<th>Iowa Attorney General</th>
</tr>
</thead>
<tbody>
<tr>
<td>510 E. 12th Street #2</td>
<td>1305 E. Walnut Street</td>
</tr>
<tr>
<td>Des Moines, IA 50319</td>
<td>Des Moines, IA 50319</td>
</tr>
<tr>
<td>Phone: 1-800-532-3213 or (515) 725-3333</td>
<td>Phone: (515) 281-5164</td>
</tr>
</tbody>
</table>
### Nebraska

**Nebraska Department on Aging**  
Department of Health & Human Services  
State Unit on Aging  
PO Box 95026  
Lincoln, NE 68509-5026  
Phone: 1-800-942-7830  
(402) 471-2307  
[http://dhhs.ne.gov/Pages/default.aspx](http://dhhs.ne.gov/Pages/default.aspx)

**Nebraska Attorney General**  
State Capitol Building, Room 2115  
Lincoln, NE 68509  
1-800-727-6432  
(402) 471-2682  
[http://www.ago.ne.gov/about](http://www.ago.ne.gov/about)

### Washington

**Washington Department on Aging**  
Aging and Long-Term Support Administration Headquarters  
4450 10th Avenue SE  
Lacey, WA 98503  
Senior Help Line: 1-866-720-4863  

**Washington Attorney General**  
1125 Washington Street SE  
PO Box 40100  
Olympia, WA 98504-0100  
(360) 753-6200  
Provider Addition/Change Form

PHYSICIAN/PROVIDER INFORMATION:  □ ADD  □ CHANGE  □ TERM*

*Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract. *If provider is terming please note reason in comments below.

NAME ________________________________ SPECIALTY ________________________________
DOB __________________ UPIN __________________ DEA# __________________ LICENSE # __________________
NPI# __________________ MEDICAID # __________________ EFFECTIVE DATE __________________

MIDLEVEL PRACTITIONER/ELIGIBLE BILLER INFORMATION:  □ ADD  □ CHANGE  □ TERM*

(additional space on other side)

NAME ________________________________ SPECIALTY ________________________________
DOB __________________ UPIN __________________ DEA# __________________ LICENSE # __________________
NPI# __________________ EFFECTIVE DATE __________________ SUPERVISING PHYSICIAN __________________
MEDICAID # __________________

GENERAL OFFICE/BILLING INFORMATION:  □ ADD  □ CHANGE  □ TERM*

(additional space on other side)

PHYSICAL PRACTICE LOCATION: OFFICE NAME ________________________________
ADDRESS __________________________ CITY __________ STATE ______ ZIP ______
PHONE ____________________________ FAX __________________________
EMAIL ADDRESS _______________________ TAX ID#** __________________________
NPI# __________________ EFFECTIVE DATE __________________

BILLING LOCATION: COMPANY NAME ________________________________
ADDRESS __________________________ CITY __________ STATE ______ ZIP ______
PHONE ____________________________ FAX __________________________
EMAIL ADDRESS _______________________ TAX ID#** __________________________
NPI# __________________ EFFECTIVE DATE __________________

**If you have a Tax ID# change, please remember to submit a new W-9 Form to Health Alliance.
If claims are filed electronically, list the vendor and contact person.

VENDOR __________________________ CONTACT PERSON __________________________ PHONE __________________
If Health Alliance has questions about the addition/change of a provider, who can we contact?

NAME __________________________ PHONE __________________

COMMENTS ________________________________

Please mail or fax copies of DEA certificate (if applicable) and state licenses for all providers.

Mail to:  Contracting & Provider Services
Health Alliance Medical Plans
301 S. Vine St.
Urbana, IL 61801
or  Fax to:  Contracting & Provider Services
Attention: Provider Relations Specialist
(217) 337-3438

cps-provchange-0214
**Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract.**

*If provider is terming please note reason in comments below.*

### ADDITIONAL MIDLEVEL PRACTITIONER/ELIGIBLE BILLER INFORMATION:

- [ ] ADD
- [ ] CHANGE
- [ ] TERM*

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- DOB
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- LICENSE #
- NPI#
- EFFECTIVE DATE
- SUPERVISING PHYSICIAN

**MEDICAID #**

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- EFFECTIVE DATE

**COMMENTS**

**If you have a Tax ID# change, please remember to submit a new W-9 Form to Health Alliance.**
MIDLEVEL PROVIDER DATA

Please complete a copy of this form for each midlevel and fax it to Kendra Pearman’s attention at (217) 337-3438.

Start Date __________________________________________________________________

Name (last, first, MI) __________________________________________________________

Degree _____________________________________________________________________

NPI # _____________________________   Medicaid # ______________________________

SSN # or Tax ID # ____________________________________________________________

Office Name _________________________________________________________________

Address ____________________________________________________________________

City _______________________________________________________________________

State ______________________________________________________________________

Zip ________________________________________________________________________

Phone _____________________________________________________________________

Fax _______________________________________________________________________

Email _____________________________________________________________________

Name of Supervising Physician ________________________________________________

Is midlevel supervised by this physician more than 50% of the time?       yes ____      no ____

DEA Number* (if applicable) __________________________________________________

Expiration Date ______________________________________________________________

*Copies of State License, State Controlled Substance License and DEA Registration Certificate REQUIRED. Behavioral Health providers who do not prescribe medications are required only to submit a copy of their State License.